Coping With Domestic Violence: The Roles Of Spirituality And Religion In The Lives Of African American Women

by
Christina G. Watlington

Dissertation submitted to the Faculty of the Graduate School
of the University of Maryland, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2005

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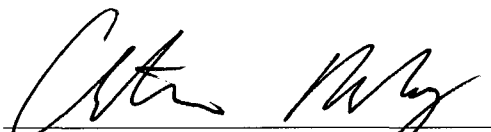
Dissertation and Abstract Approved: 

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Psychology Extern
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Watlington, C., Zoellner, L.A. & Foa, E.B. (2001). Natural recovery processes in individuals with and without acute stress disorder: A case study. Psicoterapia Cognitiva e Comportamentale, 7(2), 117-127.

Zoellner, L.A., Feeny, N.C., Alvarez, J., **Watlington, C**., O'Neill, M.L., Zager, R., Foa, E.B. (2000). Factors associated with the completion of the restraining order process in female victims of partner violence. Journal of Interpersonal Violence, 15(10), 1081-1099.

Penn, M. L; Coverdale **(Watlington), C**. (1996). Transracial adoption: A human rights perspective. Journal of Black Psychology,22(2) ; 240-245.

MANUSCRIPTS IN PROGRESS

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Watlington, C. & Batten, S.V. (2004). The roles of coping and social support in survivors of domestic violence.

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ABSTRACT

Title of Dissertation: Coping with Domestic Violence: The Roles of Spirituality and Religion in the Lives of African American Women

Christina G. Watlington, Doctor of Philosophy, 2005

Dissertation directed by: Christopher M. Murphy
Associate Professor
Psychology Department

African American women appear to be at an increased risk for experiencing domestic violence, placing them at greater risk for experiencing adverse mental health outcomes. The use of spirituality and religion has been repeatedly documented in the literature as traditional means of coping in the African American community. However, very little is known about whether such coping mechanisms influence mental health outcomes and responses to violence among victims of domestic violence.

The aims of the present study were as follows: (1) to determine whether religious involvement and spirituality were associated with fewer depression and posttraumatic stress symptoms, (2) to determine whether religious coping mediated the spirituality-mental health link, and (3) to determine whether social support mediated the religious involvement-mental health link. Exploratory analyses were also conducted to explore the association between religious variables and responses to violence (i.e., women's use of physical aggression and women's use of services), and to determine whether religious variables predict variance in PTSD symptom levels and depression above and beyond variance accounted for by traditional forms of coping, namely emotion-focused coping and problem-focused coping.

Sixty-five African American women who experienced domestic violence in the past year completed a self-report packet. Study results indicated that African American

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women who evinced higher levels of spirituality and greater religious involvement reported fewer depression symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. Findings further revealed that women who reported higher levels of spirituality reported utilizing higher levels of religious coping strategies; and women who reported higher levels of religious involvement reported higher levels of social support. Further, the social support mediation hypotheses were supported.

This study contributes to the literature by highlighting relevant coping mechanisms for this population. Indeed, spirituality and religious involvement emerged as important coping mechanisms for this sample. It is likely that discussing religious issues in therapeutic sessions may be helpful. Clinicians should consider ways in which they might use religion/spirituality as a therapeutic tool. More studies are needed to advance our understanding of the association between religious variables and mental health outcomes among victims of domestic violence.

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DEDICATION

I would like to dedicate this dissertation to the many strong, resilient and courageous women that I have had the opportunity to meet while conducting this research. It is my true hope that I have honored your struggle, your courage, and your strength in this study.

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ACKNOWLEDGMENTS

First, I would like to thank my beautiful family for their unwavering love, support and encouragement. This journey would not have been quite so rewarding without the loving support of my husband, Malik, and my extraordinary children- Ngozi and Sadiki. They gave me the will to *keep on keeping on,* and I am so very grateful to have such a wonderful family!

Second, I would also like to extend my appreciation to all of the agencies that allowed me to collect data and to all of the women who participated in this research. It was a pleasure to work with the staff and women in each of these agencies. I learned a great deal and I really admire the work and dedication of those working on behalf of families surviving domestic violence.

I also wish to express my appreciation to all of those who served on my committee: Dr. Christopher Murphy, Dr. Lisa Jordan, Dr. Kenneth Maton, Dr. Robert Deluty, and Dr. Craig Boatman. I appreciate your guidance and support.

Finally, I humbly extend my gratitude to God who is more a friend to me than I am to myself. I am grateful for the many blessings that I have been bestowed.

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TABLE OF CONTENTS

Chapter	Page
PREFACE	ii
I. Introduction	1
A. Domestic Violence in the Lives of African American Women	3
B. Negative Sequelae associated with Domestic Violence	6
1. PTSD	6
2. Depression	10
C. Responses to Domestic Violence	13
1. Utilization of Services	13
2. Women's Use of Aggression	15
D. Religion and Spirituality in the Lives of African American Women	16
E. Religion's and Spirituality's Relation to Mental Health Outcomes and Responses to Violence	19
F. Mediators of Religion and Spirituality	23
1. Religious Coping	23
2. Social Support	28
G. Present Study	31
H. Research Hypotheses	33
II. Method	35
A. Participants	35
B. Measures	35
C. Procedure	45

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D. Data Analytic Procedure..... 46

III. Results..... 49

A. Sample Description..... 49

B. Physical Abuse Characteristics..... 52

C. Characteristics of Measures..... 52

D. Bivariate Relations among Variables..... 56

E. Overview of Mediational Models..... 57

F. The Predictive Capacity of Religious Variables Above and Beyond Traditional Forms of Coping..... 69

IV. Discussion..... 72

A. Limitations..... 84

B. Implications for Psychological Research and Practice..... 87

APPENDIX 1. MEASURES..... 89

APPENDIX 2. TABLES..... 113

REFERENCES..... 116

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LIST OF TABLES

Table Page

Table 1. Sociodemographic Characteristics..... 50

Table 2. Prevalence of Interpersonal Victimization in Past 12 Months..... 52

Table 3. Characteristics of Measures..... 53

Table 4. Intercorrelations of Observed Measures..... 58

Table 5. Summary of Stepwise Regression Analyses for Spirituality Predicting Depression Symptoms..... 60

Table 6. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Depression Symptoms..... 61

Table 7. Summary of Stepwise Regression Analyses for Social Support Predicting Depression Symptoms..... 62

Table 8. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Depression Symptoms After Controlling for Social Support.. 63

Table 9. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Post-Traumatic Stress Symptoms..... 65

Table 10. Summary of Stepwise Regression Analyses for Social Support Predicting Post-Traumatic Stress Symptoms..... 66

Table 11. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Posttraumatic Stress Symptoms After Controlling for Social Support..... 66

Table 12. Summary of Stepwise Regression Analyses for Religious Variables Predicting Depression Symptoms..... 70

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Table 13. Summary of Stepwise Regression Analyses for Religious Variables Predicting PTSDSymptoms..... 70

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LIST OF FIGURES

Figure Page

Figure 1. Religious coping mediating the relation between spirituality and mental health and responses to battering outcomes..... 27

Figure 2. Social support mediating the relation between religious participation and mental health and responses to battering outcomes..... 31

Figure 3. Social support mediating the relation between religious participation and depression..... 64

Figure 4. Social support mediating the relation between religious participation and posttraumatic stress symptoms..... 67

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Introduction

Domestic violence represents a serious public health concern in the United States, and statistics indicate a very troubling picture. In the United States, an estimated 4.7 million violent crimes are committed against women annually (Abel, 2000); including 1.8 million women living with a man and an equal number who are legally separated or divorced (Campbell & Gary, 1998). Statistics indicate that domestic violence results in more injuries that require medical treatment than rape, auto accidents, and muggings combined (Abel, 2000). Moreover, 30% of female homicide victims are killed by husbands or boyfriends, making violence from male partners a leading cause of serious injury for women in the United States (Stark & Flitcraft, 1995).

The victims of domestic violence are at risk for an array of negative mental health outcomes. Depression, anxiety, posttraumatic stress disorder (PTSD), substance abuse, and suicide ideations and actions have been found to be related to domestic violence (Campbell & Lewandowski, 1997; Cunradi, Caetano, Clark & Shafer, 1999; Hampton & Gelles, 1994; Thompson, Kaslow, Kingree, 2002). Research suggests that rates of depression, suicide attempts, psychosomatic symptoms and stress are four times greater among women who are victims of domestic violence as compared to non-victims (Stets & Straus, 1990). Yet, some women are able to survive the abusive relationship with fewer negative outcomes than others (Waldrop & Resick, 2004), suggesting a need to further explore the strategies they use to safeguard their mental health.

Research on women's responses to domestic violence suggests that such responses include actively defending themselves, seeking legal and social services, and leaving the relationship (e.g., Campbell, Sharps, Gary, Campbell, & Lopez. 2002).

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Indeed, there is ample empirical evidence suggesting that women are active help seekers in extricating themselves from the violent relationship (e.g., Okun, 1986). Although women's initial attempts to leave the relationship are often unsuccessful (Campbell, Miller, Cardwell, & Belknap, 1994), research suggests that women make up to five attempts to leave their partner before ending the abusive relationship (Okun, 1986).

African American women appear to be at an increased risk for experiencing domestic violence (Campbell & Gary, 1998; Negg, Halaman, and Schulter, 1995; Rennison & Welchans, 2000). Regrettably, research on domestic violence has historically neglected the experiences of African American women, despite calls for greater inclusion of this population in studies of domestic violence (Asbury, 1987; Coley & Beckett, 1988; Lockhart & White, 1989). The small body of research that currently exists has been criticized on several grounds including inappropriate comparisons of African American women with European American women, the lack of examination of contextual variables that increase African American women's vulnerability to domestic violence and subsequent consequences (Campbell, 1993; Campbell, Masaki & Torres, 1997; Raj, Silverman,Wingwood, & DiClemente, 1999), lack of group specific data on African American women's responses to intimate partner violence (Campbell et al., 2002), and the lack of inclusion of culturally relevant protective factors that may mitigate against the negative effects of violence (Barnes, 1999).

Although there has been a growing body of literature in the area of coping over the past two decades, still very little is known about the various ways women cope with a violent relationship. The body of literature on religious coping has consistently found

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religious practices and beliefs to be indicators of well being, including greater life satisfaction, happiness, self-esteem, and positive affect (Koenig, McCullough, & Larsen, 2001). Further, religion and spirituality are variables that have been found to be very important in the African American community (e.g., Taylor & Chatters, 1991). The purpose of the present study is to extend the line of research on domestic violence in the lives of African American female victims of domestic violence by examining two culturally relevant coping mechanisms: spirituality and religious involvement. The specific aims were (1) to examine the association between selected religious variables (spirituality and religious involvement) and selected negative mental health outcomes (PTSD and depression), (2) to examine the association between the religious variables (spirituality and religious involvement) and two types of responses to violence (use of aggression and utilization of services), (3) to examine whether religious coping mediates the relation between spirituality and the four outcomes: PTSD, depression, use of aggression, and utilization of services, and (4) to examine whether social support mediates the relation between religious involvement and the four outcomes: PTSD, depression, use of aggression, and utilization of services.

Domestic Violence in the Lives of African American Women

Although domestic violence crosses all racial, ethnic, religious, age and socioeconomic strata, African American women appear to be at triple jeopardy for experiencing such violence (Campbell & Gary, 1998). Analyses of nationally representative samples have found that race in itself is not a significant factor in the incidence of domestic violence (Coley & Beckett, 1988); however, the intersection of gender, race, and socioeconomic status place African American women at an increased

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risk for abusive relationships (Negg, Halaman, and Schulter, 1995; Richie, 1994). In fact, between 1993 and 1998, African American women were victimized by intimate partners at a significantly higher rate than persons of any other race (Rennison & Welchans, 2000), and research indicates that domestic violence is the leading cause of self-reported mental and physical health problems for African American women (Saunders, 1995). Further, African American women are more likely than their European American counterparts to sustain serious and lethal injuries as a result of domestic violence (Fagan, 1996; Hampton & Yung, 1996). Consequently, the National Black Women's Health Project has identified domestic violence as the number one health issue for African American women (Joseph, 1997).

Due to economic and racial oppression endured by African American families, African American women are more likely to be vulnerable to multiple sources of stress, including inadequate educational opportunities, unemployment and underemployment, and multiple forms of racial discrimination (Myers, 1987). Indeed, women living in poverty have a particularly difficult time extricating themselves from abusive relationships and are vulnerable to persistent violence (Heron, Jacobs, Twomey, & Kaslow, 1997). Given that African American women are more likely than their White counterparts to be of lower social class (Sullivan & Rumptz, 1994) and that elevated levels of partner abuse have been reported in low income couples (Hotaling & Sugarman, 1986), African American women are at a greater risk for experiencing domestic violence and its associated psychological sequelae and have a more difficult time freeing themselves of the violence than their middle- and upper-class counterparts.

Other factors have been found to be contributors to domestic violence in the

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African American community including child sexual abuse (CSA) and neglect and HIV status. For example, Wingood and DiClemente (1996) found that African American women with a history of CSA were more likely to be battered than those women who did not have a CSA history. Wyatt, Axelroe, Chin, Carmona and Loeb (2000) found that HIV positive status and CSA history was related to severe levels of physical abuse in a sample of African American women.

African American women's responses to the violence in their lives are often influenced by the chronic experiences of racism and the social contexts in which they live (Campbell et al., 2002). Consequently, despite the serious physical and psychological threat that domestic violence poses to African American women, African American women often perceive helping professionals as insensitive to the racial and cultural contexts of their lives, preventing them from using mainstream mental health services (Asbury, 1987; Coley & Beckett, 1988). When African American women do enter into the mental health system it is usually at the behest of social service agencies, when these women are under extreme duress (Kanuha, 1994). When clinical intervention is not considered an option for African American women, they may respond to violence by actively defending themselves or reporting the incident to the police when the violence is severe (Greenfield et al., 1998). Uncovering the ways in which coping strategies among African American female victims influence negative mental health outcomes and responses to abuse may help to elucidate various cultural approaches to treatment that will be more sensitive to the needs of African American women while making clinical interventions more attractive to the African American community.

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Negative Sequelae Associated With Victimization

Posttraumatic Stress Disorder (PTSD)

African American women who are victims of domestic violence may be at increased risk for developing posttraumatic stress disorder (PTSD) due to their ethnicity and abuse status. PTSD develops in persons who have experienced a traumatic event that involves experiencing, witnessing, or being confronted with death or life threatening experiences including serious physical injury or a threat to one's physical integrity (Anderson & Black, 1995). In order to meet DSM-IV criteria for PTSD, one must meet at least one symptom of re-experiencing the trauma (e.g., dreams or recurrent thoughts), at least three symptoms of emotional numbing (e.g., feeling detached from others, restricted range of affect), and at least two symptoms of autonomic arousal (e.g., irritability or exaggerated startle response) (American Psychiatric Association [APA], 1994). Concerning ethnicity, research suggests that the rate of PTSD is elevated among ethnic minority groups because ethnic minorities are more likely to be exposed to violent crime, and they are more likely to experience hostility (i.e., experiences associated with racism) in their social environment (Marsell, Friedman, & Spain, 1992). With respect to abuse status, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association [APA], 1994) suggests that events involving interpersonal violence may be especially likely to produce severe PTSD symptoms. Indeed, research suggests that domestic violence can lead to the development of PTSD (see Kubany et al., 1995).

By the 1970's the epidemic proportion of women experiencing domestic violence was well recognized, thereby triggering research on the psychological symptoms

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common among abused women. Walker (1979, 1984), in her groundbreaking research with over 400 self-identified abused women from shelters and the community at large noted that psychological sequalae among battered women included anxiety, depression, memory loss, cognitive dissociations, reexperiencing the traumatic event when exposed to associated stimuli, feelings of helplessness, sleep and appetite disturbances, fatigue, listlessness, self-imposed isolation, and disruption of interpersonal relationships. Walker (1984) noted that these symptoms could constitute a subcategory of PTSD and coined the term *Battered Woman Syndrome* for women experiencing such symptoms in response to abusive relationships.

Since Walker's pioneering work on abused women, PTSD symptoms have been increasingly recognized in the domestic violence literature (e.g., Cascardi, O'Leary, & Schlee, 1999; Kemp, Green, Hovanitz, & Rawlings, 1995; Kubany et al., 1995). Although the rate of PTSD in the general population has been found to be about 4.6% (Resnick, Kilpatrick, Dansky, & Saunders, 1993), rates of PTSD among abused women are significantly higher. In shelter samples of battered women, PTSD prevalence has ranged from 45% to 84% (e.g., Kemp et al., 1995; Kubany et al., 1995). The prevalence rate of women involved in support groups for battered women has been estimated to be between 35% and 84% (Kubany et al., 1996; Kubany et al., 2000). In a sample of women seeking treatment for marital problems who were physically victimized by their spouse within the past year, 30% of the sample was found to meet PTSD diagnostic criteria (Cascardi, O'Leary, & Schlee, 1999). Variation in reported prevalence rates appears to differ as a function of differences across studies in the population sampled, the method of diagnostic assessment and the length of time since the traumatic event. However, overall

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it appears that shelter samples evidence the highest rates of PTSD while community samples evidence the lowest rates.

Risk factors often associated with the onset of PTSD are many. Green, Wilson, and Lindy (1985) identified three categories of risk factors contributing to the psychological impact of the traumatic event: characteristics of the event itself (i.e., severity, frequency, and type of abuse), individual characteristics (i.e., presence or absence of prior assault, sexual abuse), and characteristics of the recovery environment (i.e., negative life events, social support and coping strategies). Kemp et al. (1995) found the recovery environment to be particularly important in explaining the variance in PTSD outcome. In their study of shelter women, they found disengagement coping, lack of perceived social support and negative life events to be the strongest predictors of PTSD followed by extent of physical abuse and time out of the relationship (characteristics of the event) and prior childhood experiences and adult sexual/physical abuse (individual characteristics). Astin, Lawrence, and Foy (1993) found that violence exposure severity, recency of the last abusive episode, low social support, intercurrent life events (i.e., negative and positive life changes experienced within the preceding year), low intrinsic religiosity, and developmental family stressors predicted 43% of the variance in PTSD symptomatology. Fowler (2002) found perceived social support to predict low levels of PTSD symptomatology in her sample of African American female survivors.

Not only has physical abuse been implicated in the onset of PTSD symptoms, but also psychological abuse has been found to play a critical role in the onset of PTSD symptoms (e.g., Follingstad, Rutledge, Berg, Hause, & Polek, 1990). For instance, Kemp et al. (1995) found that 63% of the verbally abused women in their sample met PTSD

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diagnostic criteria. Cascardi, O'Leary and Schlee (1999) found that the spouse's dominance/isolation tactics predicted PTSD symptoms in their marital clinic sample. Street and Arias (2001) found PTSD symptomatology to be positively correlated with severity of psychological abuse, even after controlling for the effects of physical abuse in a shelter sample. Moreover, early qualitative research (Walker, 1979, 1984) with abused women suggested that many of the women perceived the psychological abuse to be more harmful than the physical abuse. Finally, 72% of the battered women reported that emotional abuse had a more severe impact on them than the physical abuse (Follingstad et al., 1990).

Studies examining ethnicity and PTSD prevalence in female victims of domestic violence are scarce. One study found that African American women tend to have higher rates of PTSD (21.6%) than their European American (11.5%) and Mexican American counterparts (13.1%) (McGruder-Johnson, 2000). Fowler (2002) found that 54% of her community sample of abused African American women met criteria for PTSD diagnosis. It has been argued that more research is needed in the area of PTSD and ethnicity in order to approach trauma in women of color with ethnocultural sensitivity (Root, 1996).

The aforementioned studies clearly identify PTSD as an adverse outcome for victims of domestic violence. Studies indicate that PTSD rates in battered women are significantly higher than rates in the general population, suggesting that PTSD is an outcome of domestic violence that warrants serious attention. Further, both physical and psychological abuse appear to make a significant contribution to PTSD symptoms in abused women, and factors such as individual characteristics, abuse characteristics, and aspects of the recovery environment (e.g., low social support) appear to predict the

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severity of PTSD symptoms. The additional environmental stressors of racism and violence exposure experienced by African American women may place them at an even greater risk for developing trauma symptoms. However, several of the studies utilize small percentages of African American women, making the impact of domestic violence on this population somewhat unclear. The present study examined PTSD as an adverse mental health outcome among African American female victims of domestic violence.

Depression

Another adverse mental health outcome experienced by victims of domestic violence is depression (Campbell, Kub, Belknap, & Templin, 1997; Gleason, 1993). Symptoms of depression include depressed mood, loss of interest, weight loss or gain, sleep disturbances, psychomotor agitation or retardation, energy loss, guilt, concentration difficulties and suicidal ideation (American Psychiatric Association [APA], 1994). It has been documented that approximately 4.3% of the population has depression at any given time (Anderson & Black, 1995). A factor that has been commonly noted to increase the risk of depression for African American women is poverty and its associated factors such as unemployment, lack of education, having young children, and being divorced or separated (Brown, 1990).

Although very little is known about the association between depression and domestic violence in the lives of African American women, studies do suggest that depression is the primary mental health response of battered women (e.g., Gleason, 1993). Rates of depression among abused women range from 38% to 83% (e.g., Campbell, Sullivan, & Davidson, 1995) and generally tend to be highest among women using domestic violence services (70% to 83%) (Campbell et al., 1995; Cascardi &

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O'Leary, 1992). Gleason (1993) found a higher prevalence of depression (63%) than that of PTSD (40%) in a sample of 62 battered women. Campbell et al. (1997) found 28% of their community sample to be moderately to severely depressed and 11% of their sample to be severely depressed.

Studies have sought to identify predictors of depression in abused women. With respect to abuse characteristics, the findings have been mixed. Cascardi and O'Leary (1992) found severity, but not frequency of abuse to be related to depression, while Follingstad et al. (1991) found physical violence to be the only form of abuse that was related to depression. Others (Campbell et al., 1997; Orava, McLeod, & Sharpe, 1996) have found both severity and frequency to be related to depression. In regard to individual characteristics, Campbell et al. (1997) found childhood physical abuse but not childhood sexual abuse to be a significant predictor of depression in abused women. Further, they identified aspects of the recovery environment to be important in predicting depression. These factors were self care agency (i.e. the ability to take care of one's health) and daily hassles (i.e. stressful events; self care was negatively correlated and daily hassles was positively correlated). Fowler (2002) found perceived social support and spirituality to be inversely related to depression in her sample of African American women.

Although studies have clearly cited depression as an outcome of abuse in the lives of women in general, only a few studies have examined the negative outcome of depression specifically in the lives of African American battered women. Nedd (2000), in her study of 164 abused African American women, found that most of the women had mild levels of depression while 35.7% of the sample were considered moderately

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depressed and 11.1% had severe levels of depression, as measured by scores on the Beck Depression Inventory. Campbell and Soeken (1999) conducted a longitudinal study to assess change in depressive symptomatology over time as a function of change in abuse status. They found that depressive symptoms remained for African American women whose status changed from abused to non-abused, although this same outcome was not found for non-African American women. Fowler (2002) found subgroups in her sample of African American abused women who met criteria for mild (21.5%), moderate (12.1%), and severe (6.4%) depression.

Suicidality as a symptom of depression has been examined within populations of abused African American women and the existing literature has documented an abuse-suicidal link in low-income populations (Stark & Flitcraft, 1996). Stark and Flitcraft (1996) reviewed the medical records of women suicide attempters for a history of partner abuse and found that African American women who attempted suicide were more likely than European American women to have a history of partner abuse. Kaslow and colleagues (1998) found that low-income African American women suicide attempters were 3.6 times more likely than their demographically similar non-suicidal counterparts to report physical abuse, and 3.9 times more likely to report nonphysical partner abuse.

Therefore, the data are consistent with the idea that physical abuse is related to depression with rates of depression among abused women exceeding those rates in the general population. African American women may be just as likely to experience depression as their non-African American counterparts due to poverty and associated risk factors (e.g., lack of education, unemployment, etc.). Additionally, suicide may be a frequent response to domestic violence among low-income African American women.

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The aim of this study was to elucidate factors that may be associated with depression as an outcome of abuse for African American women.

Responses to Domestic Violence

Utilization of Services

Several studies have indicated that the utilization of services that address victimization can be potentially beneficial. Sullivan and Bybee (1999) randomized abused women leaving domestic violence shelters to advocacy services versus a normal aftercare condition. Women who received advocacy services reported less violence at the 2-year follow-up assessment and a higher quality of life. Others have shown the provision of parent training and social support in the homes of abused women reduces psychological distress and improves parenting in comparison to women not receiving such services (Jouriles et al., 1998). Further, the efficacy of PTSD treatment for domestic violence victims is beginning to gain empirical support (e.g., Kubany, Hill, & Owens, 2003).

Despite the support that women can gain from accessing such services, many abused women do not utilize available services in their community. Strube and Barbour (1984) found that only about a quarter of their sample of abused women (N=251) utilized services (i.e., counseling, filing of assault charges, protection orders, and legal services). Gondolf (1998) found that only 7% of the victims in his multi-site program evaluation of abuser interventions had utilized shelter services and only 25% of this sample had participated in counseling that targeted violence. West, Kantor, and Jasinksi (1998) observed that only 3% of the sample of women from the National Alcohol and Family Violence Survey had attended a shelter, and less than 14% had talked with a mental

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health provider. More recently, Henning and Kleseges (2002) reported that only 14.9% of their sample of 1, 746 women reported prior use of formal counseling/supportive services to address the abuse. Further, Zoellner and colleagues (2002) found that for women who initiated the restraining order process, 50% failed to return to obtain a one-year restraining order. Likewise, the studies suggest that many women do not access services available to them in their community, and when they do they are not likely to persist with the process of legal services once they are initiated.

Factors related to the utilization of services have been documented in the literature. Although some suggest that severity of violence is related to utilization of services (e.g., Harris & Dewdney, 1994; Sullivan, 1991), others have found severe violence to be unrelated to seeking services (West et al., 1998). Mixed results have also been found for socio-economic status (e.g., Hutchinson & Hirschel, 1998; West et al., 1998) and victim's age (e.g., Hutchinson & Hirschel, 1998; West et al., 1998). Marital status has also been linked to utilization of services such that women in dating relationships are much less likely to utilize legal and supportive services than their married counterparts (Hutchinson & Hirschel, 1998). Additionally, having a child living at home is related to help-seeking behavior among abused women (e.g., Johnson, 1990).

Race has also been found to be related to utilization of services. Hutchinson and Hirschel (1998) found that African American victims were less likely to use formal social support systems than European-American victims. Gondolf, Fisher, and McFerron (1988) observed that African American women were more likely to turn to the police for assistance, while European American women were more likely to access social service agencies. The reluctance of African American women to seek formal help is often a

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reflection of feeling left out of the formal system (Bent-Goodley, 2001). Further, African American women may believe they have a special responsibility to protect their men who have historically been victims of a racist system (Richie, 1994). It has also been noted that African American women traditionally turn to medical facilities rather than agencies offering mental health services (Coley & Beckett, 1988). Indeed, research suggests that compared to European American women, African American women are 4 times less likely to go to a shelter, two times less likely to obtain an order of protection, and 1.5 times less likely to call the police out of fear of contributing to the victimization of African American men (Joseph, 1997). The present study examined coping strategies that may be associated with use of services among African American women.

Women's Use of Aggression

A burgeoning area of research suggests that battered women do use violence against their partners (e.g., Archer, 2000; Stets & Straus, 1990). In fact, three out of every four women that are abused reciprocate violence (Campbell et al., 2002). Regardless of the reasons for using aggression, the results of such violence are likely to be very detrimental to the victims and may pose an even greater risk for severe violence and injury. Further, women's abusive behavior has been found to predict the use of physical and psychological abuse by men involved in a domestic violence treatment program (Watlington & Murphy, 2002). Therefore, such behavior may contribute risk for further victimization.

Studies have indicated that African American women are more likely to reciprocate violence in response to battering than their European American counterparts. The First National Family Violence Survey (Straus, Gelles, & Steinmetz, 1980) found

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that African American women were more than twice as likely to engage in severe acts of violence against their husband compared with European American women. A study by Uzell and Peebles-Wilkins (1989) found that African American women were more likely to fight back in response to victimization and that African American women were more likely to kill an abusive spouse. Indeed, self-defense is one of the most common causes of homicide among African American women (Campbell & Gary, 1998).

Use of aggression among women may be recognized as one of the only responses among African American women who see no other alternative to the abuse. Very few studies have examined factors that protect against this response. However, social support has been implicated in decreasing violence in the African American community (e.g., Browne, 1987). The present study explored the relation between coping mechanisms and use of physical violence among African American women.

Religion and spirituality in the lives of African American women

Given the findings that document depression and trauma symptoms as common negative mental health outcomes for victims of domestic violence, and the literature on women's responses to violence, it seems particularly important to examine factors that may mitigate adverse mental health outcomes and responses to battering that can increase the woman's risk for re-abuse. African American women historically have been considered as individuals who persist despite major enduring life stressors (Neighbors, Jackson, Bowman & Gurin, 1983). The use of spirituality and religion has been repeatedly documented as traditional means of coping in the African American community (e.g., Hill et al., 1995). In fact, numerous studies have found that religious means of coping are the most common forms of coping utilized during times of stress

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(e.g., Koenig, George, & Siegler, 1988; Pargament et al., 1990). However, psychologists have generally ignored religious means of coping as a valid area of exploration in research and practice. Examination of religious variables is particularly critical for African American women, as they tend to rely on these means of coping more than traditional mental health services (Myers, 1987). Further, spirituality and religion have become quite controversial topics with some arguing that the degradation of women is the cornerstone of most religions (Horton & Williamson, 1988), and others highlighting the beneficial effects of religious practices (e.g., Calhoun, Cann, Tedeschi, & McMillan, 2000). To improve the mental health of African American women, African American psychologists and other mental health professionals assert that spirituality and religion are helpful tools in healing as they are factors that have historically influenced the physical and mental health of African American women (Myers, 1987).

Religion has traditionally played an important role in the African American community. Throughout much of American history, religious institutions have occupied an important position in the Black community, and studies have reported that a majority of African Americans are affiliated with a religious denomination (e.g., Taylor & Chatters, 1991). By religious affiliation, 52% of African Americans report their religious denomination as Baptist, almost 12% identify as Methodist, and about 6% identify as Catholic (Taylor & Chatters, 1991). Further, research has indicated that African Americans are generally more religious than European-Americans, regarding religion as more personally important and attending religious services more often than European Americans (Gallup, 1984).

The overarching role of religion in the lives of African Americans can be linked

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to religion being a vehicle to speak to issues of oppression, quest for liberation, love, hope and justice (Taylor & Chatters, 1991). As a group of people historically subjected to a variety of oppressive and adverse conditions, the affective components of spirituality and religion have served to mitigate fear, anxiety, frustration, and hopelessness in the lives of African Americans (Mattis & Jaggers, 2001). Furthermore, the church has traditionally played a role in the family life of African Americans by offering a variety of forms of instrumental support such as financial assistance, food, shelter, clothing, medical care, child care, and counseling (Billingsley, 1992; Caldwell, Chatters, Billingsly, & Taylor, 1995). According to Moore (1991), the church is a forum to promote a sense of community, provide role models, teach effective coping skills, and provide an outlet to organize shared experiences into a new identity. Likewise, the church tends to represent a support system, providing a sense of tradition, moral guidance and services (Morris & Robinson, 1996; Taylor & Chatters, 1991).

For African American women who are often socialized into the church at a younger age than their male counterparts, scores on measures such as religious salience, commitment and involvement tend to be higher than their male counterparts (e.g., Taylor & Chatters, 1991). Further, African American women have been found to be more likely to use prayer to cope with obstacles than have African American men (Neighbors et al., 1983). Therefore, religion and spirituality are particularly important variables to examine among African American women.

"Religion" and "spirituality" are often used interchangeably; however, research suggests that they are in fact distinct domains of human life. *Spirituality* concerns the more personal and private dimensions in one's life and most often is recognized as being

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concerned with the transcendent, addressing questions about life's meaning (Underwood & Teresi, 2002). Carrol (1997) suggested that *spirituality* denotes a relationship with God that fosters a sense of meaning, purpose and mission in life, whereas *religion* flows from spirituality and expresses an internal subjective reality in institutionalized forms, rituals, beliefs, and practices. Mattis (2000) conducted a qualitative study to assess African American women's definitions of spirituality and religion. Content analyses of women's written narratives and in depth interviews revealed three key differences between religion and spirituality. First, women described spirituality as the internalization of positive values, whereas religion was described as being associated with organized religion. Second, whereas religion was defined as a path, spirituality was defined as an outcome. Finally, whereas religion was tied to worship, spirituality was associated with personal relationships. This paper explored these variables as separate dimensions of one's religious life and examined their associations with a variety of outcomes for abused African American women. For the purpose of the study, *spirituality* was operationally defined as the individual's perception of the transcendent (i.e., God) in her daily life and her perception of her interaction with the transcendent in life. On the other hand, *religious involvement*, another dimension in the study, was operationally defined as frequency of religious involvement and private religious practices in one's life.

Religion's and Spirituality's Relation to Mental Health Outcomes and Responses to Violence

The salutary effects of religion and spirituality on mental health have been well documented in a number of empirical studies. For example, in a recent review of 68 studies examining the association between suicide and religion, 84% of the studies found

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that lower rates of suicide were found among the religious (Koenig & Larsen, 2001). Additionally, McCullogh and Larson (1999) reviewed more than 80 studies examining the association between religious factors and depression and found that persons who both participated in a religious group and highly valued their religious faith were at a substantially reduced risk of depressive disorder, whereas people without any religious links were at an increased risk (as much as 60%) for major depression.

Comparative studies of African Americans and European-Americans generally have found religion to play a more salient role in mitigating negative mental health outcomes among African Americans. For example, St. George and McNamara (1984) examined the role of religious affiliation and religious attendance in predicting global happiness in African American and European American participants. Although strength of religious affiliation did not predict global happiness for European Americans, findings indicated that it did increase global happiness for African Americans above and beyond demographic controls. In a more recent study, Blaine and Crocker (1995) found religious belief salience to be more predictive of psychological well-being among African American than European-American students.

The relation between religion/spirituality and domestic violence has been virtually ignored. A few studies have examined the link between religious affiliation and attendance and the perpetration of domestic violence. Gelles (1974) found that risk of domestic violence was especially high when partners differed in their religious affiliations. Brinkerhoff, Granden, and Lupri (1992) found Conservative Christians and those not affiliated with religion to be the most abusive. Further, Conservative Christian women reported engaging in higher levels of violence than other women. Ellison,

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Bartowski, and Anderson (1999) found regular attendance to be inversely associated with self-reported perpetration of domestic violence for men and women but that men who held more conservative theological views perpetrated domestic violence at higher rates than those with less conservative views.

Religion can influence domestic violence in various ways by making women more vulnerable to the violence or serving as a source of support for battered women. It can also legitimate and fail to adequately condemn the violence (Bell & Mattis, 2000). Indeed, it has been argued that religion tends to promote the maintenance of the family, blinding clergy and others to the magnitude of the problem (Bell & Mattis, 2000). Bell and Mattis (2000) noted that some religious traditions hold that even in the face of abuse, women must not separate from or divorce their husbands and that biblical references have been used to legitimize the use of physical coercion. On the other hand, research shows that religious communities can provide a resource for women through the use of informal support networks of the church (McAdoo, 1995), by providing strategies for coping with distress and adversity, and by providing tangible and moral support (Maton, 1989; McAdoo, 1995).

There is a relative dearth of information regarding the roles that spirituality and religion play in the lives of abused women. Astin et al. (1993) examined the impact of an aspect of spirituality, intrinsic religiosity (as measured by a single item) on PTSD symptomatology among a sample of abused women. Although intrinsic religiosity was found to be negatively correlated with one measure of PTSD (i.e., the Impact of Events Scale) such that those high in intrinsic religiosity reported lower levels of PTSD, it was positively correlated with another measure of PTSD (i.e., the PTSD symptoms checklist).

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Sullivan (1993) measured intrinsic religiosity in order to determine its impact on PTSD symptoms in abused women and found that intrinsic religiosity was related to lower levels of PTSD symptomatology. Fowler (2002) examined the role of spirituality as a protective factor in guarding against PTSD, depression and alcoholism in a community sample of African American women and found that spirituality, as measured by a 5-item scale that measures aspects of daily experiences, was only significantly negatively correlated with depression. No associations were found between spirituality and PTSD or substance abuse. Coker et al. (2002) used a 2-item religiosity index in their study of battered women that included: (1) "what religion or spirituality offers most is comfort in times of trouble and sorrow", and (2) "your whole approach to life is based on your religion." It was found that higher levels of religiosity were not associated with a reduction in risk of negative mental health outcomes; however the 2-item measure renders these results inconclusive.

Other studies have examined the roles of spirituality and religion in the lives traumatized individuals. Weinrich, Hardin, and Johnson (1990) found that religion was a primary positive coping strategy among nursing students who experienced Hurricane Hugo. Zeidner (1993) similarly found that frequent prayer and worship attendance were associated with better mental health outcomes among those who experienced the devastating impact of a major Midwestern flood. Kennedy, Davis, and Taylor (2000) found spirituality to be correlated with well-being in a sample of female victims of sexual assault.

Regarding responses to battering, only a few studies have examined the roles of spirituality and religion in contributing to a successful end to an abusive relationship. In

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their qualitative study, Senter and Caldwell (2002) focused on the spiritual experiences of nine women who successfully interrupted the cycle of violence. Emerging themes that contributed to ending the relationship were a belief in God, forgiveness, and frequent prayer and meditation. In a qualitative study of abused women, church participation and involvement and the development of a relationship with God, were found to be important in the process of leaving and remaining out of the abusive relationship (Senter & Caldwell, 2002). Horton and Williamson (1988) found that religious women tended to make use of resources such as shelters, friends, judges, and professional counselors as often as their non-religious abused counterparts.

In summary, there is a relative dearth of research regarding the roles of religion and spirituality in predicting mental health outcomes and responses to violence among abused women. However, the literature suggests that religious variables may, indeed, be related to fewer negative mental health outcomes among traumatized populations.

Mediators of Religion and Spirituality

The roles of spirituality and religion in reducing negative mental health outcomes raises the question of whether there are unique processes that serve as a bridge between these variables and psychological outcomes. Two general processes have been recognized in the literature: religious coping and social support.

Religious Coping

Coping is a process by which individuals attempt to manage a situation perceived as stressful (Lazarus & Folkman, 1984). Researchers have distinguished between a variety of coping activities (e.g., problem-focused, emotion-focused, active, planning, seeking help, behavioral disengagement, etc.) (Carver, Scheier, & Weintraub, 1989).

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Religious coping is beginning to gain more recognition.

Religious coping is multidimensional and spans the range of coping activities from emotion-focused coping to problem-focused, active to passive, and positive to negative (Pargament, 1997). Pargament (1997) argues that during times of stress, objects of significance[1] such as the sense of meaning, intimacy with others, physical and mental health, and personal control are threatened. He notes that studies have generally shown a clear connection between stressful life events and religion because religion is able to offer a variety of coping methods for conserving those objects of significance that have been threatened. Religious coping serves several ends during times of stress, including the enhancement of self-esteem, control, meaning, intimacy with others, hope, growth, belonging and personal identity (e.g., Ellison, 1994).

Pargament (1997) argues that religion provides both cognitive and behavioral coping mechanisms, making religious coping a powerful form of coping. Indeed, it has been argued that religious coping predicts variance in psychological outcomes above and beyond non-religious forms of coping (Pargament, 1997), therefore making religious coping a very unique form of coping. Religion enables people to appraise negative events from a different vantage point. The use of such cognitive coping mechanisms becomes an opportunity for crisis to be transformed into an opportunity to develop closeness with God. Further, behavioral coping takes place such that one engages in task oriented activities such as reading the Bible, watching religious television, reciting sacred phrases, having a period of quiet prayer, having a conversation with clergy and participating in

[1] In Pargament's model of coping, he lays out several assumptions, one of which is that people seek significance. He notes that significance is, in part, a phenomenological construct embodying the experience of caring, attachment and attraction. Significance is also object oriented (e.g., we care for something). Significant objects can be material, physical, social, psychological and/or spiritual.

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religious rituals.

Religious coping is commonly used among those with fewer resources. For instance, Neighbors et al. (1983) surveyed African Americans to uncover the one coping response that helped them the most when dealing with a personal problem. Overall, 44% said that prayer was the one coping response that helped the most. Additionally, prayer was cited most commonly among the elderly, the less educated, those of lower socio-economic status and women. In fact, it has been found that among African American victims of domestic violence who lack resources, problem-focused coping, a more direct form of coping to alter the circumstances appraised as threatening, is associated with more PTSD and depression (Kocot & Goodman, 2003). Therefore, various coping mechanisms may yield different results based on the ecological context in which one experiences the stressor.

Victims of domestic violence are less likely to have access to resources and thus may rely more on religious coping in response to their abuse. However, only a handful of studies have examined religious coping among victimized women. Bowker (1988), in her study of 1000 battered women across the United States found that one-third of the battered women received help from clergy, suggesting the important role that the clergy might play in reducing domestic violence. Common help behaviors delivered by the clergy were focused talking, direction and problem solving, material aid and direct service, and directly intervening in the environment to reduce stress.

Horton, Wilkens and Wright (1988) used questionnaires to compare the coping activities of abused wives who defined themselves as religious with victims of abuse who defined themselves as nonreligious. While the religious women remained in their

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marriages longer than non-religious women, they were not acquiescent. They tended to work harder to save their marriages by using more resources such as religious leaders and counselors in their attempts to resolve their situation. Instead of withdrawing, a large majority of religious victims made use of family and friends, and legal intervention was used by over 50% of the religious women. Further, religious victims were just as likely to tell someone about their abuse as the nonreligious women and separated just as frequently.

Religious coping has been identified as a variable that can account for the link between global measures of religiousness and mental health outcomes. A number of studies have found that measures of religious coping predict outcomes to life stressors significantly, even after removing the effects of global religious measures such as intrinsic religiousness and average frequency of prayer (Pargament, 1997). Smith et al. (2000) found that religious dispositional variables as measured by frequency of prayer were associated with psychological outcomes and that the association was mediated by religious coping. Fabricatore, Handel, Rubio and Gilner (2004) found that collaborative religious coping (which refers to sharing the responsibility for problem solving with God) mediated the association between religiousness (i.e., the extent to which they integrated God into their everyday lives) and distress. The explanation for these findings is that one's orienting system is unable to explain how that faith is used in specific encounters, but rather it is the specific methods of coping that have the more proximal implications for positive outcomes. That is, during stressful encounters, one's religious beliefs or practices have to be translated into specific forms of coping. These findings suggest a model in which religious coping mediates the association between global measures of

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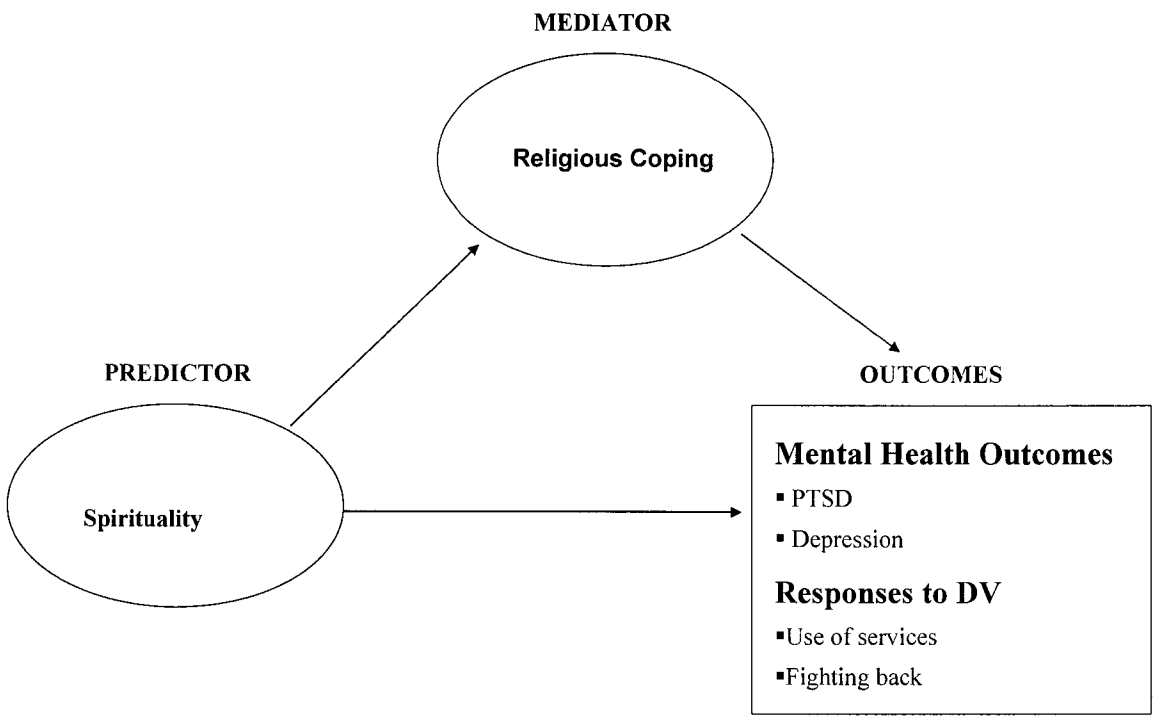
religiousness (i.e., spirituality) and outcomes of major life events (see Figure 1). This model provided one conceptual framework for the present study. For the purpose of this study, a measure of spirituality was used to test the mediational model[2].

Figure 1. Religious coping mediating the relation between spirituality and mental health and responses to battering outcomes.



[2] Although global measures of religiousness also include religiousness involvement, the mediating role of religious coping was only of interest for spirituality, as another mediator was examined for religious involvement.

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Social Support

Social support refers to "functions performed for a distressed individual by significant others such as family members, friends, coworkers, relatives and neighbors" (p. 417) (Thoits, 1986). It has been described as a type of coping assistance (Thoits, 1986). Social support may promote positive mental health by providing valued social identities (Mitchell & Hodson, 1983). It can also influence women's responses to violence by providing tangible support that can aid the victim in extricating herself from the relationship (Bowker, 1986). Moreover, women who are victims of domestic violence may be in particular need of social support for a variety of reasons. It has been noted that abusive men tend to socially isolate their victims from friends and family (Browne, 1987; Dobash, Dobash, & Cavanagh, 1985). Women who are victims of domestic violence may not seek out social support due to concerns of being stigmatized by others, fear of retaliation by the perpetrator, or the belief that domestic violence is a private rather than public matter (Mitchell & Hodson, 1983; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992). Further, because the abuse may be chronic, abused women over time may deplete the emotional and material resources of providers (Thompson et al., 2000).

More studies are beginning to examine social support as it applies to the African American community. Research has found social support to be particularly important for reducing domestic violence among African Americans (e.g., Browne, 1987; Cazenave & Straus, 1979). The unemployment rates for African Americans are more than double those for whites, and social support networks play an important role in buffering against the socioeconomic forces that may contribute to stress and violence (Hill, 1972).

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Likewise, studies have indicated that access to a network of family and friends is important in African American families and it may be related to the reduction of violence in the lives of women (e.g., Browne, 1987; Cazenave & Straus, 1979).

Several studies have cited the role of social support in reducing negative mental health consequences among African American victims of domestic violence. Sullivan and Rumptz (1994) found that the use of short-term advocacy services (a form of formal social support) increased women's access to important resources while also reducing their depression, fear and anxiety over time. Coker et al. (2002) found that abused women with higher social support scores were significantly less likely to report current poor physical and mental health, depression, PTSD symptoms, and suicide ideation than were abused women reporting lower social support. Fowler (2002) found that overall perceived social support was negatively related to PTSD symptoms and depression in a sample of African American women who experienced domestic violence.

The Black church has been described as a vehicle through which valued social resources can be accessed (Williams et al., 1991). Indeed, the Black church historically has been involved in the provision of emotional support (e.g., companionship, prayer support) as well as tangible support (e.g., goods, services) to their members (Taylor & Chatters, 1988). Taylor and Chatters (1988), for example, found that among African American church members, church attendance, church membership, religious affiliation and subjective religiosity were all related to receipt of support. Other studies have found that churchgoers tend to have larger social networks than those who do not attend church (e.g., Bradley, 1995). In a review of 20 studies of more general populations, 19 reported at least one statistically significant association between a religious variable and greater

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social support. It has been suggested, in fact, that religious involvement increases social support, which in turn decreases distress (e.g., Aneshensel, 1992).

The mediating role of social support in reducing negative mental health outcomes has not been examined among victims of domestic violence. However, studies have examined social support as a mediator in the religious involvement-mental health link. Ellison et al. (2001) examined whether social variables (contact with family members, positive social support from family and friends, and negative social interaction with family and friends) mediated religious effects on psychological distress. Results indicated that there was a significant direct effect of religious involvement on psychological distress, however social support failed to explain the religious effects. However, Jang and Johnson (2004) analyzed survey data from a nationally representative sample of African American adults and found that social support was able to explain the relation between religious involvement and psychological distress. The investigators concluded that the mediating process of social support on the religious involvement-mental health link is more applicable to African Americans because they are more likely to experience saluatory effects of religious involvement.

Indeed, social support could aid those who are religiously committed by serving as a form of coping assistance, providing an opportunity for emotional release, or providing valuable support that can reduce the likelihood of adverse affects of the abuse. This study explored the mediating role of social support on the religious involvement-mental health link and the religious involvement-responses to violence link (See Figure 2).

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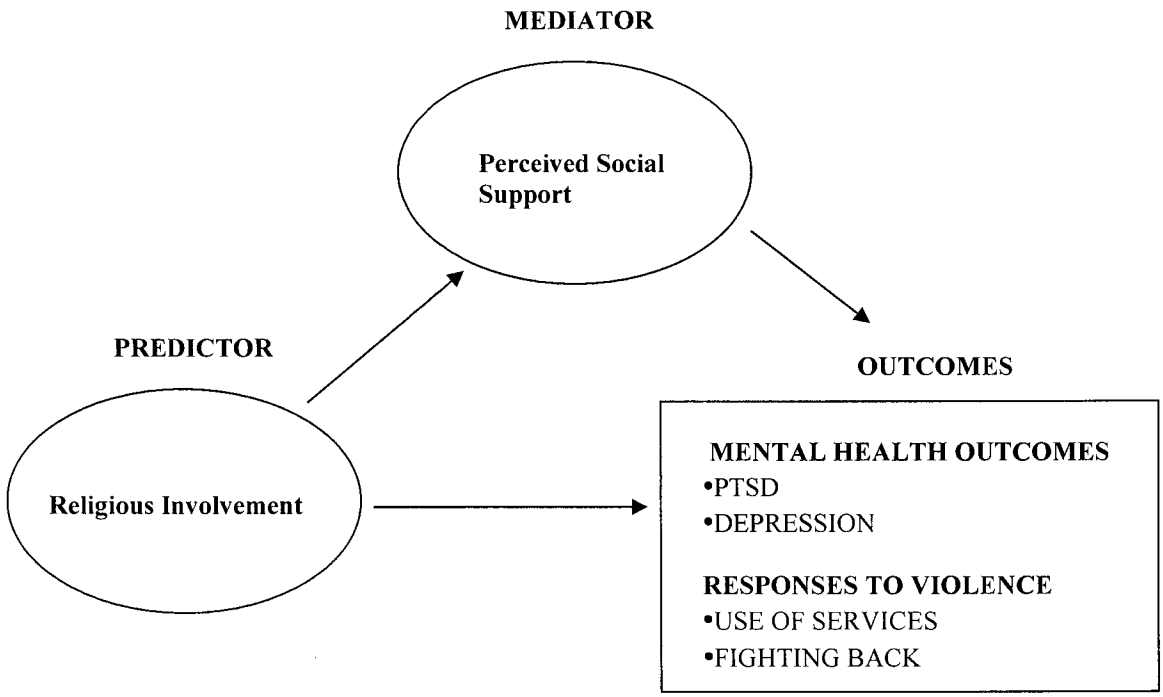
Figure 2. Social support mediating the relation between religious participation and mental health and responses to battering outcomes.



Present Study

The role of religion and spirituality in the lives of African American women is understudied. In general, the studies of human responses to crisis from the religious/spiritual perspective have often been neglected. Considering the role that religion and spirituality play in the lives of many African Americans, it is important to begin to examine these variables in greater detail.

As mentioned earlier, to date there are only a handful of studies that have examined these protective factors among a domestic violence sample. Further, previous studies have typically focused on limited measures of religiosity (i.e., mostly one- or two-item measures of intrinsic religiosity), excluding the unique impact of other types of

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religious variables on mental health outcomes. There are even fewer studies that have particularly targeted an African American domestic violence sample to examine these variables. Fowler (2002) conducted a study to examine the role of spirituality and social support in predicting the mental health outcomes of African American women who were victims of domestic violence. The results of her study indicated that spirituality was not related to PTSD symptoms, although it was related to depression and alcohol abuse in her sample. However, the study only utilized a 5-item measure of spirituality and did not examine religious coping or religious involvement in particular. This is problematic considering that the religious coping literature suggests that the specific methods of coping rather than one's general religious orientation have the most proximal implications for one's mental health. Further, considering the multidimensionality of religiosity and spirituality, it is also possible that all aspects of the dimension were not fully covered in the five-item measure utilized in Fowler's study. Also, Fowler's study utilized a sample of African American women from the community. It has been suggested that shelter samples may experience more severe symptoms of depression and trauma, suggesting a need to examine the impact of religious variables among those with more severe trauma histories. Finally, no study to date has examined unique processes that may serve as a bridge between these religious variables and adverse mental health outcomes among an African American domestic violence sample. The purpose of the present study was to gain a broader understanding of the impact of these constructs in the lives of abused women by not only examining mental health outcomes, but also by examining responses to battering that could serve as potential risks for re-abuse and the processes that may serve as a bridge between religious variables and mental health

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outcomes.

Therefore, the primary purpose of the present study was to extend the line of research on religion and spirituality by examining the mediating roles of social support and religious coping in influencing two mental health outcomes: PTSD and depression. An additional aim of the study was to determine the predictive power of the religious variables on mental health outcomes above and beyond traditional means of coping: emotion-focused coping and problem-focused coping. Finally, the study also explored how religion and spirituality influence women's use of formal support services and their use of aggression. The independent variables of interest were spirituality and religious involvement.

Research Hypotheses

Based upon research addressing religion, spirituality, coping strategies and social support, the following hypotheses were proposed.

I. Religious Coping as the Mediator

1. Spirituality will be associated with the mental health outcomes of PTSD and depression.
2. Religious coping will mediate the association between spirituality and mental health outcomes of PTSD and depression.

II. Social Support as the Mediator

3. Religious involvement will be associated with the mental health outcomes of PTSD and depression.
4. Social support will mediate the association between religious involvement and mental health outcomes of PTSD and depression.

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Exploratory Questions

Additionally, the study sought to answer the following questions:

1) Are religious involvement and spirituality associated with women's utilization of services and use of aggression?
2) If religious involvement and spirituality are associated with women's utilization of services and use of aggression then
    (1) Does social support mediate the association between religious involvement and the two outcomes (women's use of aggression and use of services)?
    (2) Does religious coping mediate the association between spirituality and the two outcomes (women's use of aggression and use of services)?
3) Do religious coping, religious involvement, and spirituality predict variance in PTSD symptom levels and depression above and beyond variance accounted for by traditional forms of coping: emotion-focused coping and problem-focused coping, such that those with high scores on the various religious measures will have low scores on measure of PTSD and depression?

No formal hypotheses are being made regarding these questions, as there is very little empirical literature on these topics.

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Method

Participants:

Participants included 65 women of African descent recruited from six domestic violence agencies in Maryland and Washington, D.C. between April of 2004 and May of 2005. The participating agencies were the Family Crisis Center of Baltimore County (N= 34) the Family Crisis Center of Prince George's County, Inc. (N=11), the Domestic Violence Center of Howard County (N=6), the Abused Person's Program of Montgomery County (N=4), the House of Ruth's Domestic Violence Residential Program- Herspace (N=5) and the House of Ruth's Transitional Program – Freedom Place (N=5). All are comprehensive domestic violence agencies offering family psychotherapy, safe shelter, victim advocacy, community education, and crisis hotline counseling.

The criteria for being accepted into the study included: (1) over 18 years of age, (2) of African descent, and (3) experienced physical abuse in the past 12 months. Women were recruited into the study if they were receiving victim services (e.g., counseling, shelter) at the participating agency or if their partners were receiving counseling for domestic abuse perpetration[3].

Measures

The questionnaire packet included questions regarding demographics, severity and frequency of physical and psychological abuse during the past year, aspects of current social support, types of current coping activities, types of services utilized, religious involvement, spiritual experiences, and symptoms related to depression and

[3] Partners of men receiving services for domestic violence were only recruited at one agency, the Domestic Violence Center of Howard County.

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posttraumatic stress disorder.

Demographic Questionnaire

Questions eliciting age, ethnicity, marital status, length and type of relationship with the current partner (i.e., the partner who recently assaulted the woman), employment status, educational status, religious affiliation, religious involvement, and income were used for describing the sample (see Appendix A).

Physical and Psychological Aggression

The Revised Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; see Appendix B), the most widely used measure for assessing marital violence, was used to assess levels of physical assault, physical injury, sexual assault, and psychological aggression experienced by the female partner and the levels of physical aggression perpetrated by the female partner. The CTS-2 is a 78-item scale that asks about the relationship conflict behaviors of the respondent and the respondent's partner. Five subscales make up the CTS-2: Negotiation (5 items; e.g., "suggested a compromise to an argument"), Psychological Aggression (8 items; e.g., "called partner fat or ugly"), Physical Assault (12 items; e.g., "kicked, bit, or punched partner'), Sexual Coercion (7 items; e.g., "used force to make partner have sex"), and Injury (6 items; e.g., "partner was cut or bleeding"). Although separate reliability or validity information has not been published for African Americans, the original version of the CTS has been used in national surveys that have included a substantial number of African American adults. Internal consistency for studies using an African American female sample has been found to be good. For example, Kocot and Goodman (2003) found the Cronbach's alpha for the physical assault subscale to be .94 in their sample of African American women. The

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subscales used for this study have been found to have good internal consistency (Psychological aggression = .79; Physical assault = .86; Sexual = .87; Injury = .95) (Straus et al., 1996).

The scale authors (Straus et al., 1996) also reported subscale intercorrelations as evidence of the validity of the CTS2. Specifically, the physical assault subscale has been found to be correlated with the sexual coercion subscale ($\underline{r}$ = .90 for men; $\underline{r}$ = .26 for women), the psychological aggression subscale ($\underline{r}$ = .71 for men; $\underline{r}$ = .67 for women), and the injury subscale ($\underline{r}$ = .91 for men; $\underline{r}$ = .42 for women). The psychological aggression subscale has been found to be correlated with sexual coercion ($\underline{r}$ = .66 for men; $\underline{r}$ = .25 for women) and injury ($\underline{r}$ = .63 for men; $\underline{r}$ = .41 for women)[4]. Additionally, the significant associations were not found for two pairs of theoretically unrelated variables, namely negotiation and sexual coercion ($\underline{r}$ = .03 for men; $\underline{r}$ = .10 for women) and negotiation and injury ($\underline{r}$ = .01 for men; $\underline{r}$ = .16 for women) (Straus et al., 1996). These findings were based on a college dating sample.

The CTS-2 items ask how many times in the past 12 months the participant has experienced each specific act and how many times the participant has perpetrated each specific act against their relationship partner. In keeping with prior research, a frequency- based variable was created by summing the frequency of each endorsed item (Straus et al., 1980). Frequency of abusive behavior is rated on a scale ranging from 0 (Never) to 6 (More than 20 times) in the past 12 months. These subscale scores are computed by summing the relevant items, with higher scores reflecting a greater degree of abuse. The CTS2 does include a response category, 7 (not in the past 12 months, but it

[4] Of note, higher correlations are found for men because research has shown that men are more likely than women to use coercion to obtain sex and physical assaults by men result in serious injury more often than

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did happen). However, because scores from the previous 12 months were desired rather than a prevalence measure of physical assault (e.g., did an assault ever occur), category 7 was scored as a 0 for the current study. Finally, a larger scale of physical abuse was created by adding the physical aggression, injury and sexual aggression subscales.

The physical aggression items from the CTS1 (Straus, 1979; see Appendix C) were used to screen women for study eligibility[5]. Women were asked whether a significant other within the past year (1) threw something at her, (2) pushed grabbed or shoved her, (3) slapped her, (3) kicked, bit or hit her with a fist, (4) hit or tried to hit her with something, (5) beat her up, (6) choked her, (7) threatened her with a knife or gun, (8) used a knife or fired a gun. Only women who answered affirmatively to at least one of these eight questions met the physical violence criterion for the study. All women screened met study eligibility.

Social Support

The Interpersonal Support Evaluation List (ISEL; Cohen, Mermelstein, Kamarack, & Hoberman, 1985; see Appendix D) is a 40-item true-false instrument that measures the perceived availability of four social support resources: tangible support, self-esteem support, belonging support, and appraisal support. Each subscale consists of 10 items. The *tangible* subscale measures perceived availability of material aid (e.g., "There is no one I could call on if I needed to borrow a car for a few hours"); the *appraisal* subscale measures the perceived availability of someone to talk to about one's problems (e.g., 'There is at least one person I know whose advice I really trust"); the

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physical assaults by women.

[5] The CTS1 items were chosen to screen for physical violence as opposed to the CTS2 items because it provides a briefer screening tool to assess physical violence than the 12 physical assault items of the CTS2. It was thought that these items were sufficient to select those women who had been victims of physical

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self-esteem subscale measures the perceived availability of a positive comparison when comparing one's self with others (e.g., "Most of my friends are more interesting than I am"); and the *belonging* subscale measures the perceived availability of people one can do things with (e.g., 'There are several different people with whom I enjoy spending time").

The ISEL was found to be moderately correlated ($r = .46$) with another validated measure of social support, the Inventory of Socially Supportive Behaviors (ISSB; Barrera, Sandler, & Ramsay, 1981). Demonstrating its discriminant validity, the ISEL was found not to be correlated significantly with a measure of social anxiety, the Social Anxiety and Distress Scale (SADS). Normed on samples of college students, the ISEL has been found to have good internal reliability with alpha coefficients ranging from .88 to .90 for the total scale. The internal reliability for the subscales has been found to be satisfactory: appraisal (.77-.92), self-esteem (.60-.68), belonging (.71-.74), and tangible support (.60-.68) (Cohen & Wills, 1985). Confirmatory factor analysis supports the use of this instrument as an index of general social support (Brookings & Bolton, 1988). Intercorrelations among three of the subscales (self-esteem, belonging, and appraisal) also suggest two factors: tangible support, composed of the tangible support subscale and emotional support, composed of the other three scales (Brookings & Bolton, 1988). The ISEL has been shown to have good internal consistency in a sample of African American women who were victims of abuse (alpha = .92) (Kocot & Goodman, 2003).

The ISEL was used in this study to measure overall social support. Total scores could range from 0 to 40, with higher scores indicating more support.

Spirituality

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violence in the past year .

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Spirituality was assessed using the Daily Spiritual Experiences Scale (DSE; Underwood & Teresi, 2002; see Appendix E). The DSE is a 16-item scale that measures aspects of day- to-day spiritual experiences (e.g., "I feel God's presence," "I find strength in my spirituality," "I feel God's love for me through others"). The first 15 items are scored using a 6-point scale (i.e., 1= many times a day, 2=every day, 3=most days, 4=some days, 5=once in a while, and 6=never or almost never). The 16th item (i.e., In general, how close do you feel to God?) has four response categories: *not close at all, somewhat close, very close, as close as possible*. Originally, it was scored such that lower scores reflect more frequent daily spiritual experiences. However, for the sake of ease in interpreting the results, the measure was scored such that higher scores reflect higher daily spiritual experiences (i.e., 6= many times a day, 5=every day, 4=most days, 3=some days, 2=once in a while, and 1=never or almost never). Scores could range from 16 to 94.

High internal consistency is reported for the scale, with alphas ranging from .94 to .95 (Underwood & Teresi, 2002). Regarding convergent validity, the DSE has been found to be significantly positively correlated with the Life Orientation Test, a measure of optimism, (r =.34) (Scheirer, Carver, & Bridges, 1994), Berkman's scale of Perceived Social Support (.18) (Seeman & Berkman, 1988), and Quality of Life (SF-36) (.24) (McHorney, Ware, Lu, & Sherbourne, 1994). The DSE has been found to not be correlated with sleep problems (r = -.06) and physical ailments (r = -.11). Further, the DSE has been found to be negatively correlated with measures of alcohol consumption (i.e., the sum of alcohol intake combining wine, beer and liquor) (r = -.20), anxiety, as assessed with the State-Trait Anxiety Inventory (r = -.39) (Spielberger, Gorush, Lushene,

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Vagg, & Jacobs, 1983), and depression, as assessed with the Center for Epidemiological Studies-depression scale (r = -.22) (Radloff, 1977).

Religious Involvement

Religious involvement was assessed by combining two commonly used questions of religious attendance (Wingrove & Alston, 1974) with 6 questions from the Religious Background and Behavior Scale (RBB; Connors, Tonigan, & Miller, 1996) (see Appendix F). The two-item measure of religious attendance asks the following questions: (1) "How often do you attend religious services" using a 6 point scale ranging from 1 (Never) to 6 (More than once a week) and (2) "Besides religious services, how often do you take part in other activities at a place of worship" using a 9-point scale ranging from 1(Never) to 9 (Several times a week). For the 6 items taken from the RBB, respondents are asked to indicate on an 8-point scale, the frequency with which they had engaged in the following behaviors during the past year: thought about God, prayed, meditated, attended worship services, read-studied scriptures-holy writings, and had direct experiences of God. Altogether, scores can range from 8 to 63. Attendance at religious services has not been tested for reliability and validity, but it has been studied for over 50 years in the Gallup Poll (Wingrove & Alston, 1974). The correlation between the items on the two-item measure in the current study was .58, and the alpha was .73 for the 8-item measure created for the study.

Religious Coping

The *turning to religion* subscale of the COPE (Carver et al., 1989; see Appendix G) is a 4-item religious/spiritual coping subscale. Respondents were asked to indicate the extent to which they employed spiritually-based coping when confronted with the abuse

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over the past year using a 4-point scale (1= "I didn't do this at all"; 2= "I did this a little bit"; 3= "I did this a medium amount"; 4= "I did this a lot"). Scores could range from 4 to 16. The scale has been found to have high internal consistency (r = .92) (Carver et al., 1989). Further, it has been found to be associated with optimism (r = .15) and monitoring (r = .20)[6] among a sample of undergraduate students coping with stress (Carver et al., 1989).

Emotion-Focused Coping

The *seeking social support for emotional reasons* subscale of the COPE (Carver et al., 1989; see Appendix G) is a 4-item subscale that is considered to be an aspect of emotion-focused coping. Respondents were asked to indicate the extent to which they got moral support, sympathy and understanding from friends when confronted with the abuse over the past year using a 4-point scale (1="I didn't do this at all"; 2="I did this a little bit"; 3= "I did this a medium amount"; 4= "I did this a lot"). Scores could range from 4 to 16. The scale has been found to have good internal consistency (r = .85) (Carver et al., 1989).

Problem-Focused Coping

The *active coping* subscale of the COPE (Carver et al., 1989; see Appendix G) is a 4-item subscale that is similar to the core of what Lazarus and Folkman (1984) term problem-focused coping. Respondents are asked to indicate the extent to which they took active steps to try to ameliorate the effects of the abuse over the past year using a 4-point scale (1="I didn't do this at all"; 2="I did this a little bit"; 3= "I did this a medium amount"; 4= "I did this a lot"). Scores could range from 4 to 16. The scale has been

[6] Monitoring is seeking out information about one's situation and its potential impact. It is a subscale of the Miller Behavioral Style Scale (Miller, 1987).

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found to have adequate internal consistency (r = .62). Further, it has been found to be correlated with several theoretically related measures including optimism (r =.32), controllability of the stressor (r =.21), self-esteem (r =.27), type A personality (r =.30), and anxiety (r = -.25) (Carver et al., 1989).

Utilization of Services

Actions Specific to Abuse (ASA; Nurius, Furrey, & Berliner, 1992; see Appendix H) is a 13-item scale that was used to assess utilization of services in this sample. There is no validity or reliability information on this measure. This measure was created for use in a previous study of coping responses to domestic violence; however one item was added to the list for the current study (i.e., "obtaining an order from the court for your partner to stay away from you"). Specifically, respondents were asked whether they had or had not undertaken a list of protective and help-seeking behaviors in response to the abuse (e.g., "Sought professional help for self," "Sought emergency shelter," "Notified authorities"). Since some services may not be applicable to the respondent (e.g., "Sought professional help for your child"), a "not applicable" response option was provided. The total score was computed in two ways- first by adding the total number of actions taken to create an indicator of overall behavioral responsiveness to the abuse, and second by computing the total percentage of "applicable" services received.

Depression

The Beck Depression Inventory (BDI; Beck, Steer & Garbin, 1988; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; see Appendix I) was used to assess depressive symptoms. The BDI contains 21 items with scores ranging from 0 (low depression) to 3 (maximum depression) for each item. Total BDI scores between 14 and 20 are indicative

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of moderate depression, whereas scores above 21 suggest severe depression. The BDI has been found to have good reliability, with a split-half reliability coefficient of .86, and a test-retest reliability coefficient of .75 (Beck et al., 1988).

The concurrent validities for the BDI with respect to clinical ratings and the Hamilton Psychiatric Rating Scale for Depression (HRSD) are high. The mean correlations of the BDI samples with clinical ratings on the HRSD were.72 and .73 respectively for psychiatric patients and .60 and .74 respectively with non-psychiatric patients (Beck et al., 1988). In regard to discriminant validity, the BDI was more highly correlated with scores on the depression subscale of the SCL-90 than on the anxiety subscale of the SCL-90 (Beck et al., 1988).

PTSD

The PTSD checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993; see Appendix J) is a 17-item self-report instrument based on the Diagnostic and Statistical Manual of Mental Disorders (4^{th} edition) (American Psychiatric Association, 1994) criteria for PTSD. Participants were asked to rate on a scale of 1 (not at all) to 5 (extremely) the extent to which they were bothered by each of the 17 items in the past month. Respondents in the study were asked to consider each symptom with respect to their experience of abuse. Scores could range from 17 to 85.

The PCL has demonstrated good internal consistency (coefficient alpha = .97) in a sample of 123 Vietnam veterans (Weathers et al., 1993). In a sample of 169 low-income, battered African American women the Cronbach's alpha for the PCL was .96 (Kocot & Goodman, 2003). Further, the PCL has demonstrated a test-retest reliability of .88 for participants with 1-week retest intervals, and concurrent validity with other PTSD scales

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such as the Mississippi Scale (.93) (Weathers et al., 1993) and the Clinician Administered PTSD Scale (.93) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). In a sample of motor vehicle accident victims and sexual assault victims, the PCL yielded sensitivity of .94 and specificity of .83 and diagnostic efficiency of .94 with a cut off score of 44 (Blanchard et al., 1996).

Procedure

Authorization to collect data was obtained from the Institutional Review Board of the University of Maryland, Baltimore County. Domestic violence agencies within the Maryland and Washington D.C. metropolitan area were contacted in order to obtain permission to recruit women at their agencies. Of the seven agencies contacted, six agencies agreed to participate in the study. These agencies included the Domestic Violence Center (DVC) of Howard County, Maryland, the Family Crisis Center of Baltimore County (FCCBC), the Family Crisis Center of Prince George's County (FCCPG), the Montgomery County Abused Person Program (MCAPP), House of Ruth Domestic Violence Residential Program – Herspace and House of Ruth's Transitional Housing- Freedom Place. Participants receiving counseling and shelter services were recruited at the end of group or at times deemed appropriate by agency staff. At this time, the primary investigator explained the purpose of the study, and asked if they would be willing to participate in a study investigating women's responses to domestic violence. It was further explained that participating or refusing to participate was unrelated to, and would have no bearing on the services the women were receiving at the agency. Finally, participants were informed that they would be compensated $10 for their participation in the study. Potential participants then read the informed consent and decided whether to

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participate.

At the DVC, partners of men receiving services for intimate partner violence were referred to the primary investigator by agency staff if they met study eligibility. The primary investigator contacted eligible participants by phone to explain the purpose of the study and answer any questions that the participant might have. Interested participants were sent the packet and the consent form. Participants were contacted by phone after the packet was received to further explain the consent form. Participants then signed the consent form, completed the packet, and mailed the materials to the primary investigator. Once the materials were received, the primary investigator sent the payment in the mail to the participant.

Instruments were presented in the packet in two orders to examine order effects (see Osberg, 1985). Packet A included the following order: 1) demographic information, 2) CTS-2 (women's report of partner behavior), 3) ISEL, 3) DSE, 4) COPE, 5) Religious Involvement, 6) Open-ended questionnaire about religious beliefs, 7) CTS-2 (women's report of her behavior), 8) Utilization of Services, 9) BDI and 10) PCL. Packet B included the following order: 1) demographic information, 2) CTS-2 (women's report of partner behavior), 3) BDI, 4) PCL, 5) CTS-2 (women's report of her behavior), 6) Utilization of Services, 7) ISEL, 8) DSE, 9) Religious Involvement, 10) COPE, 11) Religious Involvement, and 12) Open-ended questionnaire about religious beliefs. Participants were randomly administered either Packet A or B. The results showed no significant order effect on PTSD symptoms ($t(63) = 1.85$, $p > .05$) and depression symptoms ($t(63) = .15$, $p > .05$).

Data Analytic Procedure

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A power analysis was conducted using G*Power to determine the appropriate sample size for detecting the upper limit of a medium effect size (f^2=.22). Conventional effect sizes are as follows: small (.02), medium (.15), and large (.35). With five predictors in the multiple regression equation, sixty-five subjects was calculated as a sufficient number of subjects with power equal to .80, the conventional minimum for detecting significance (Cohen, 1977).

Prior to the analysis, all variables were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analyses. Prior to analysis, a square root transformation was applied to women's frequency of physical aggression scores from the CTS-2 due to moderate skewness. Demographic data were analyzed to allow comparisons with other studies. Correlations were conducted to determine the univariate relationships among predictor variables and outcome variables. Multiple regression analyses were conducted to test the unique contribution of independent variables to the prediction of the dependent variables. All multiple regression analyses controlled for personal income, physical assault, psychological aggression and time since most recent episode of physical assault. Personal income and time since most recent episode of physical assault were treated as dichotomous variables for the multiple regression analyses. Personal income was coded 1 for "less than $10.000" and 2 for "more than $10,000." Time since most recent episode of physical assault was coded 1 for "within the last 6 months" and 2 for "6-12 months ago." All other variables were treated as continuous variables.

Additional analyses were conducted to examine the associations between subscales of the PCL checklist and religious variables (see Appendix K) and to examine

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the associations between the covariates and mental health outcomes (see Appendix L).

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Results

Sample Description

In all, 72 potential participants were invited to take part in the study and consented. Of these 72, 66 returned questionnaires. Of the questionnaires returned, 1 was eliminated from analyses due to preponderance of missing data (i.e., several questionnaires were not completed). This participant indicated that she did not complete the packet because she did not think that the questions applied to her. Demographic data for those who did not return their packets are not available.

Participants ranged in age from 18 to 52. All the participants were of African descent with most of the participants (73.8%) identifying as African American . A majority of the participants identified as Baptist (46.2%), and most of the women (75.4%) were recruited from shelter services. With regard to education, employment, and income, 56.9% of the participants received less than a college education, 61.6% reported being unemployed at the time of the study, and 54.7% of the participants reported a personal income of less than $10, 000. Concerning relationship characteristics, all of the participants reported being physically abused. At the time of the study, approximately 30.8% of the participants reported that they were currently involved in a relationship with the abusive partner. In a separate question about contact, approximately 21.6% reported having contact with the abusive partner at least once a month for the purpose of being a couple. Approximately 63.5% of the women reported being separated from their partner for less than 6 months. With regard to the most recent episode of physical abuse, 13.8% reported physical abuse within the month of completing the study (see Table 1).

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Table 1. Sociodemographic Characteristics

Variable	Number	Percentage of Sample (n = 65)
Mean Age		
32.22 (SD = 7.45, range 18-52)		
Ethnicity		
African	10	15.4
African-American	48	73.8
Caribbean	4	6.2
Any Other African Background	3	4.6
Recruitment Source		
Shelter	49	75.4
Outpatient Group Therapy	10	15.4
Victim Outreach	6	9.2
Religious Affiliation		
Baptist	30	46.2
Lutheran	2	3.1
Pentecostal	4	6.2
Holiness	3	4.6
Catholic	2	3.1
Muslim	2	3.1
AME	2	3.1
Methodist	2	3.1
Other	15	23.1
None	2	3.1
Educational Status		
Did not finish high school	17	26.2
Did not finish high school but have a GED	11	16.9
High School Diploma	9	13.8
Some College	18	27.7
Bachelor's Degree	8	12.3
Graduate School	2	3.1
Employment Status		
Full time	21	32.3
Part time	4	6.2
Unemployed, worked within the past year	23	35.4
Unemployed, did not work in the past year	17	26.2

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Personal Income		
Less than $10,000	35	54.7
$10,001 - $20,000	8	12.3
$20,001 - $30,000	8	12.3
$30,001- $40,000	6	9.2
Over $40,000	7	10.7
Marital Status		
Married and living together with partner	5	7.7
Married but not living together currently	23	35.4
Cohabitating with partner	4	6.2
Never married	25	38.5
Divorced	7	10.8
Widowed	1	1.5
Relationship Information		
Currently involved with abusive partner	20	30.8
Currently not involved with abusive partner	45	69.2
Contact		
Daily or almost every day	4	6.2
3-5 times per week	4	6.2
1-2 times per week	2	3.1
1-2 time per month	1	1.5
less than once a month	3	4.6
never	11	16.9
not applicable	38	58.5
Length of time separated		
Less than one week	4	6.2
1-2 weeks	10	15.4
3-4 weeks	8	12.3
1-2 months	9	13.8
3-4 months	8	12.3
5-6 months	1	1.5
7-9 months	7	10.8
10-12 months	4	6.2
More than 12 months	6	9.2
Not applicable	6	9.2
Time Since Most Recent Physical Abuse Episode		
Less than 1 week ago	5	7.7
1-2 weeks ago	12	18.5
3-4 weeks ago	9	13.8
1-2 months ago	16	24.6

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3-4 months ago	3	4.6
5-6 months ago	3	4.6
7-9 months ago	8	12.3
10-12 months ago	9	13.8

Physical Abuse Characteristics

As Table 2 depicts, participants reported relatively high levels of physical abuse. The vast majority (84.6%) experienced at least 1 incident of severe physical abuse during the 12 months preceding their involvement in the study. About 53.2% participants reported at least 1 incident of severe injury, and roughly 49.2% reported at least one incident of severe sexual violence. Table 3 displays the means, standard deviations, and ranges for the physical abuse variables and other continuous variables in the study. As the table reveals, women reported relatively low levels of physical abuse perpetration (mean = 6.11, SD= 10.00)[7].

Table 2. Prevalence of Interpersonal Victimization in Past 12 Months

	Type of Violence							
	Physical		Sexual		Injury		Psychological	
Level of Violence	n	%	n	%	n	%	n	%
None	0	0	25	38.5	11	16.9	9	13.8
Minor	62	97	38	58.5	54	73.8	61	90.8
Severe	55	84.6	32	49.2	35	53.2	60	92.3

Characteristics of Measures

Table 3 presents the descriptive univariate statistics for each variable measured in

[7] A square root transformation was applied to women's frequency of physical aggression due to moderate skewness and kurtosis. After transformation, the descriptives were as follows: mean = 1.67, sd = 1.84, range = 0 - 6.86.

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the study. Cronbach's alpha coefficients were determined for the scales to measure levels of internal consistency in the current study. Reliability was not reported for services utilized since it is a categorical measure.

Table 3. Characteristics of Measures

Variable	M	SD	Range	Cronbach's α
CTS-2 Physical Assault Victimization	23.28	18.69	1-71	.93
CTS-2 Psychological Aggression	24.55	12.98	0-48	.88
CTS-2 Sexual Coercion	10.20	12.68	0-42	.92
CTS-2 Physical Assault Perpetration	6.11	10.00	0-47	.84
CTS-2 Injury	6.59	6.24	0-26	.76
Social Support Total (ISEL)	25.42	9.43	5-39	.93
Daily Spiritual Experiences (DSE)	72.55	12.38	33-93	.89
Religious Coping	13.89	2.67	6-16	.85
Religious Involvement	38.03	7.36	26-51	.73
Emotion-focused coping	11.82	3.61	4-16	.88
Problem-focused coping	12.40	3.18	4-16	.85
Depression (BDI)	17.45	12.30	0-42	.93
PTSD symptoms (PCL)	43.44	15.85	18-75	.94
Number of services used out of 13	9.04	2.17	5-13	
Proportion of applicable services used	.72	.17	.38-1.00	

PTSD symptoms

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The PCL showed high internal consistency in this sample (Cronbach's alpha = .94). Using the recommended screening cutoff of 44 for probable PTSD diagnosis, 47.7% of the current sample met criteria for PTSD[8]. This finding is consistent with another study's estimate of diagnosable PTSD in a sample of African American battered women (Kocot & Goodman, 2003).

Depression symptoms

The BDI showed high internal consistency for the study sample (Cronbach's alpha = .93). Symptom scores on the BDI are classified in the following categories: minimal, 0-13; mild, 14-19; moderate, 20-28; and severe, 29-63. Twenty-one percent met criteria for moderate depression, 36.9% met criteria for severe depression, and the remaining scored below the cutoff for moderate depression. This is consistent with the level of depression found in other studies of African American battered women (see Kocot & Goodman, 2003)

Perceived Social Support

The ISEL, measuring overall social support, showed a high level of internal consistency in this sample (Cronbach's alpha = .93). Further, the mean score on the ISEL (M= 25.42) reported in Table 3 is consistent with averages reported in other studies (e.g., Goodman et al., 1999; Kocot & Goodman, 2003). For example, the average level of social support reported in Kocot and Goodman's study was a mean of 29.2 (SD = 8.5, range = 5-40).

Spirituality

The DSE showed high internal consistency (Cronbach's alpha = .89). The vast

[8] A limitation of this cutoff is that the total score of the PCL does not necessarily indicate endorsement of symptoms in a pattern that fits the DSM-IV criteria (endorsing 1 re-experiencing items, 2 arousal items,

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majority of the sample reported high levels of spirituality. In a sample of African American women using the shorter version of the measure (Fowler, 2002), 70% of the women reported high levels of spirituality. Quite similarly, 61.5% of women in this study reported high levels of spirituality, with scores over 70.

Religious Coping

The religious coping measure showed high levels of internal consistency (Cronbach's alpha=.85). Although there are no prior published reports for the religious coping measure among survivors of domestic violence, findings among college samples were found to be in the same general range (α = .92; M = 11.89; SD = 2.26) (Carver et al., 1989).

Religious Involvement

Both the 2-item and the 8-item measure were examined. The 8-item measure created for the study showed good internal consistency, with an alpha coefficient equal to .73 for the study sample, while the 2-item measure showed lower reliability (Cronbach's alpha = .58). Based on the better reliability of the 8-item measure, it was utilized for all study analyses. Because the measure was created for the purpose of this study, comparisons could not be made with other studies.

Problem- and Emotion-Focused Coping

Problem-focused coping and emotion-focused coping showed high internal consistency, with alphas equal to .85 and .88 respectively. In a sample of college students, reliability, mean and standard deviation for the emotion-focused coping scale was found to be in the same general range (α = .85; M = 11.01; SD = 3.46). For the problem-focused coping measure, the statistics were found to be different among a

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and 3 avoidance items.)

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college sample (α = .62; M = 11.89; SD = 2.26) (Carver, Scheier, and Weintraub, 1989).

Utilization of Services

Women in this study reported using a relatively large number of services (mean = 9.04). Further, of the applicable services available to the women, 72% of those services were utilized.

Bivariate Relations Among Study Variables

Pearson correlations of all study variables are presented in Table 4. As illustrated in Table 4, several correlations were found among the main study variables.

Posttraumatic Stress Symptoms: Higher levels of exposure to physical assault (r =.38, p <.01) and psychological abuse (r =.25, p <.05) were related to higher levels of PTSD symptoms. Further, higher levels of religious involvement (r = - .25, p <.05) and higher levels of social support (r = - .59, p <.01) were associated with lower levels of PTSD symptoms.

Depression Symptoms: With respect to depressive symptoms, higher levels of exposure to physical assault (r =.41, p <.01) and psychological abuse (r =.33, p <.01) were related to higher levels of depressive symptoms. Further, those who reported higher levels of PTSD symptoms reported higher levels of depressive symptoms (r = .72, p <.01). Also, higher levels of spirituality and religious involvement were related to lower levels of depressive symptoms (r = -.28, p<.05; r = -.29, p< .05) and women who reported using more services also reported less depressive symptoms (r = -.28, p<.05). Finally, women who utilized more emotion-focused coping strategies and who reported higher levels of social support reported fewer depressive symptoms (r = -.42, p<.01; r = -.61, p<.01).

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Religious Involvement: Religious involvement was related to other religious variables – spirituality and religious coping. Those who reported higher levels of spirituality reported higher levels of religious involvement (r = .47, p<.01), and those who reported higher levels of religious coping reported higher levels of religious involvement (r= .33, p<.01). Further, those who evidenced greater levels of religious involvement reported utilizing more emotion-focused coping (r = .43, p<.01) and problem-focused coping (r = .33, p<.01) strategies. Finally, religious involvement was positively related to levels of social support (r=.28, p<.05).

Religious Coping: Religious coping was related to problem-focused coping such that those who reported utilizing more religious coping strategies reported using more problem-focused coping strategies (r = .55, p < .01).

Spirituality: High levels of spirituality were found to be related to high levels of religious coping (r = .41, p<.01). Further, those who evidenced higher levels of spirituality reported utilizing more emotion-focused coping (r = .36, p<.01) and problem-focused coping (r = .26, p<.05) strategies. Finally, high levels of spirituality were related to high levels of social support (r=.32, p<.01).

Women's use of aggression: Higher levels of physical abuse and psychological aggression by the respondent's partner were related to higher levels of her use of physical aggression (r's = .45 and .31, respectively).

Overview of Mediational Models

Two mediators were examined in the present study: religious coping and social support. To establish the significance of mediation, Baron & Kenny (1986) note that the following conditions must hold: (a) the independent variable (e.g.., spirituality) must be

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Table 4. Intercorrelations of Observed Measures (n = 65)

	1	2	3	4	5	6	7	8	9	10	11	12
1. Depression	—	.72**	-.28*	-.29*	.00	-.61**	-.28*	.41**	.33**	.20	-.42**	-.06
2. PTSD		—	-.20	-.25*	.06	-.59**	-.09	.38**	.25*	.06	-.43**	.04
3. Spirituality			—	.47**	.41**	.32**	.05	-.05	.04	-.09	.36**	.26*
4. Religious Involvement				—	.33**	.28*	.21	-.09	-.04	-.17	.43**	.33**
5. Religious Coping					—	-.10	-.01	.03	.09	-.08	.22	.55**
6. Social Support						—	.21	-.37**	-.18	-.20	.37**	.04
7. Utilization of Services							—	.13	.08	-.09	.07	.17
8. Physical Assault Victimization								—	.78**	.45**	-.33**	-.21
9. Psychological Aggression Victimization									—	.31*	-.26*	-.11
10. Physical Assault Perpetration										—	-.22	-.27*
11. Emotion-focused Coping											—	.47**
12. Problem-focused Coping												—

* $p < .05$ ** $p < .00$

associated with the outcome variable (e.g., depression); (b) the IV must be related to the hypothesized mediator (e.g., religious coping); (c) the hypothesized mediator must be associated with the dependent variable; (d) when the mediator is statistically controlled, a previously significant relationship between the independent and dependent variables is no longer significant or is significantly reduced in effect size. Baron & Kenny (1986) further recommend using a procedure developed by Sobel (1982), known as the *Sobel test* to calculate the indirect effect of the independent variable on the dependent variable via the mediator. It provides a direct test of the significance of the mediational pathway. It tests the significance of the difference between the total effect (the effect of the IV on the DV via the mediator) and the direct effect (the effect of the IV on the DV). For this study, the *Sobel test* was calculated using MedGraph (Jose, 2003).

Multiple regression analyses at each step were only conducted when simple bivariate correlations were found to be significant and covariates were deemed necessary.

Model 1: Testing the Mediating Role of Religious Coping in the Spirituality-Depression Relation.

The first two criteria for showing mediation were supported as spirituality was related to depression symptoms ($r = -.28$, $p < .05$), such that those with high levels of spirituality reported less symptoms of depression. Multiple regression analysis was conducted to test whether spirituality predicted variance in depression above and beyond that accounted for by abuse characteristics (i.e., physical assault and psychological aggression and time since most recent episode of physical assault), and personal income. As shown in Table 5, the association remained significant after controlling for abuse characteristics and personal income.

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Bivariate analysis was used to test whether spirituality was related to religious coping. As shown in Table 4, spirituality was positively related to religious coping, such that those with who reported higher levels of spirituality reported higher levels of religious coping ($r = .41$, $p<.01$). Bivariate analysis revealed that religious coping was not significantly related to depression ($r = .00$, $p>.05$).

Table 5. Summary of Stepwise Regression Analyses for Spirituality Predicting Depression Symptoms.

Variable	B	*SE B*	*ß*
Step 1			
Physical Aggression	.11	.12	.29
Psychological Aggression	.01	.21	.02
Income	-5.51	2.93	-.22
Episode of Abuse [a]	-5.41	3.33	-.19
Step 2			
Physical Aggression	.12	.12	.32
Psychological Aggression	-.01	.21	-.01
Income	-4.59	2.87	-.19
Episode of Abuse	-5.72	3.23	-.21
Spirituality	-.24	.11	-.24*

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .06$ for Step 2; $F_{change} = 4.94$, $p<.05$
*$p<.05$ **$p<.01$.
[a] Time since most recent episode of physical assault.

Model 2: Testing the Mediating Role of Religious Coping in the Spirituality-PTSD Relation.

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Only the second criterion for showing mediation was supported as spirituality was related to religious coping. As Table 4 illustrates, spirituality was not significantly related to posttraumatic stress symptoms (r =-.20, p>.05). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Further, bivariate analyses revealed that religious coping was not significantly related to posttraumatic stress symptoms (r =.06, p>.05).

Model 3: Testing the Mediating Role of Social Support in the Religious Involvement-Depression Relation.

For this model, the criteria for showing mediation were met. As Table 4 illustrates, religious involvement was related to depression (r = -.29, p<.05), such that those who reported higher levels of religious involvement reported lower levels of depression[9]. However, as shown in Table 6, the association did not remain significant after controlling for abuse characteristics and personal income.

Table 6. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Depression Symptoms.

Variable	B	*SE B*	*ß*
Step 1			
Physical Aggression	.11	.12	.29
Psychological Aggression	.01	.22	.02
Income	-5.51	2.93	-.22
Episode of Abuse[a]	-5.41	3.33	-.19
Step 2			

[9] Note that this relation failed to be significant when the 2-item measure of religious involvement was used

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Physical Aggression	.11	.12	.29
Psychological Aggression	.02	.21	.03
Income	-3.83	3.09	-.16
Episode of Abuse [a]	-5.49	3.29	-.19
Religious Involvement	-.31	.19	-.19

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .03$ for Step 2; $F_{change} = 2.50$, $p>.05$
*$p<.05$
**$p<.01$
[a] Time since most recent episode of physical assault.

Bivariate analysis was used to test whether religious involvement was related to social support. As shown in Table 4, religious involvement was related to social support ($r = .28$, $p<.05$), such that those who reported higher levels of religious involvement reported higher levels of social support. Further, bivariate analyses revealed that social support was significantly related to depression ($r = -.61$, $p>.01$). Further, as shown in Table 7, the association remained significant after controlling for abuse characteristics and personal income. Finally, Table 8 reveals that the association between religious involvement and depression was no longer significant after controlling for social support. Further, the association between religious involvement and depression was reduced to -.13 after controlling for social support. A Sobel test was calculated to test the significance of the mediational pathway. Results indicated that mediation occurred, (sobel z value = -2.10, $p<.05$) (See Figure 3).

Table 7. Summary of Stepwise Regression Analyses for Social Support Predicting Depression Symptoms.

Variable	B	*SE B*	*ß*
Step 1			

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Physical Aggression	.12	.07	.33
Psychological Aggression	-.02	.17	-.02
Income	-5.48	2.90	-.22
Episode Abuse[a]	-5.50	3.31	-.19
Step 2			
Physical Aggression	.03	.06	.09
Psychological Aggression	.13	.15	.14
Income	-1.91	2.74	-.08
Episode of Abuse [a]	-2.52	3.04	-.09
Social Support	-.63	.16	-.48**

Note. $R^2 = .28$ for Step 1; $\Delta R^2 = .16$ for Step 2; $F_{change} = 16.27$, $p<.01$
*$p<.05$
**$p<.01$
[a] Time since most recent episode of physical assault.

Table 8. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Depression Symptoms After Controlling for Social Support.

Variable	B	*SE B*	*ß*
Step 1			
Social Support	-.79	.13	-.61**
Step 2			
Social Support	-.74	.13	-.57**
Religious Involvement	-.23	.17	-.14

Note. $R^2 = .36$ for Step 1; $\Delta R^2 = .02$ for Step 2; $F_{change} = 1.69$, $p>.05$

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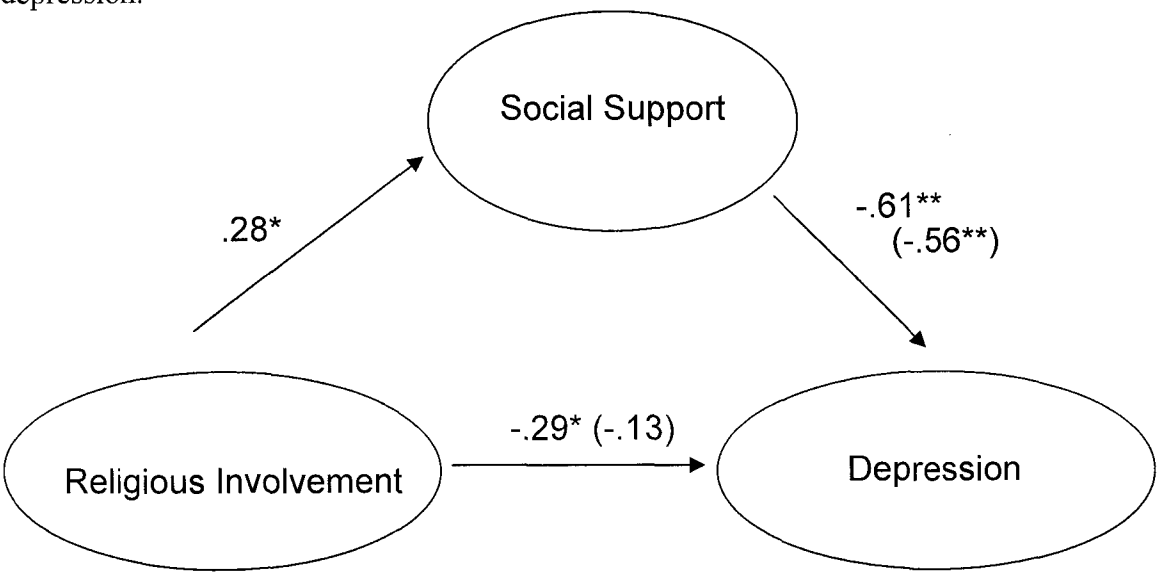
*p<.05
**p<.01

Figure 3. Social support mediating the relation between religious participation and depression.



Model 4: Testing the Mediating Role of Social Support in the Religious Involvement-PTSD Relation.

The criteria for showing mediation were supported, as religious involvement was related to social support. Further, as Table 4 illustrates, higher religious involvement was significantly related to less posttraumatic stress symptoms (r =-.25, p<.05). Multiple regression analysis was conducted to test whether religious involvement predicted variance in posttraumatic stress symptoms above and beyond that accounted for by abuse characteristics (i.e., physical assault and psychological aggression and time since last abusive episode), and personal income. As shown in Table 9, the association did not remain significant after controlling for abuse characteristics and personal income. Finally, bivariate analyses revealed that social support was related to posttraumatic stress

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symptoms (r =-.61, p>.05), such that those with high levels of social support evinced lower levels of posttraumatic stress symptoms. Further, as shown in Table 10, the association remained significant after controlling for abuse characteristics and personal income. Finally, Table 11 reveals that the association between religious involvement and posttraumatic stress symptoms was no longer significant after controlling for social support. Further, the association between religious involvement and depression was reduced to -.09) after controlling for social support. A Sobel test was calculated to test the significance of the mediational pathway. Results indicated that mediation occurred, (sobel z value = -2.09, p<.05) (see Figure 4).

Table 9. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Post-Traumatic Stress Symptoms.

Variable		B	*SE B*	*ß*
Step 1				
	Physical Aggression	.20	.09	.43*
	Psychological Aggression	-.21	.22	-.18
	Episode of Abuse [a]	-6.82	4.38	-.18
	Income	-5.73	3.84	-.19
Step 2				
	Physical Aggression	.19	.08	.41
	Psychological Aggression	-.19	.22	-.15
	Income	-3.92	4.07	-.12
	Episode of Abuse [a]	-6.86	4.35	-.19
	Religious Involvement	-.33	.26	-.15

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Note. $R^2 = .23$ for Step 1; $\Delta R^2 = .02$ for Step 2; $F_{change} = 1.59$, $p > .05$
*$p < .05$
**$p < .01$
[a] Time since most recent episode of physical assault.

Table 10. Summary of Stepwise Regression Analyses for Social Support Predicting Post-Traumatic Stress Symptoms.

Variable	B	*SE B*	*β*
Step 1			
Physical Aggression	.20	.09	.43*
Psychological Aggression	-.21	.22	-.17
Income	-5.73	3.84	-.18
Episode of Abuse[a a]	-6.81	4.37	-.19
Step 2			
Physical Aggression	.09	.08	.18
Psychological Aggression	-.01	.21	-.01
Income	-1.07	3.64	-.03
Episode of Abuse [a]	-2.93	4.04	-.08
Social Support	-.82	.21	-.49*

Note. $R^2 = .23$ for Step 1; $\Delta R^2 = .16$ for Step 2; $F_{change} = 15.67$, $p < .05$
*$p < .05$
**$p < .01$.
[a] Time since most recent episode of physical assault.

Table 11. Summary of Stepwise Regression Analyses for Religious Involvement Predicting Posttraumatic Stress Symptoms After Controlling for Social Support.

Variable	B	*SE B*	*β*
Step 1			

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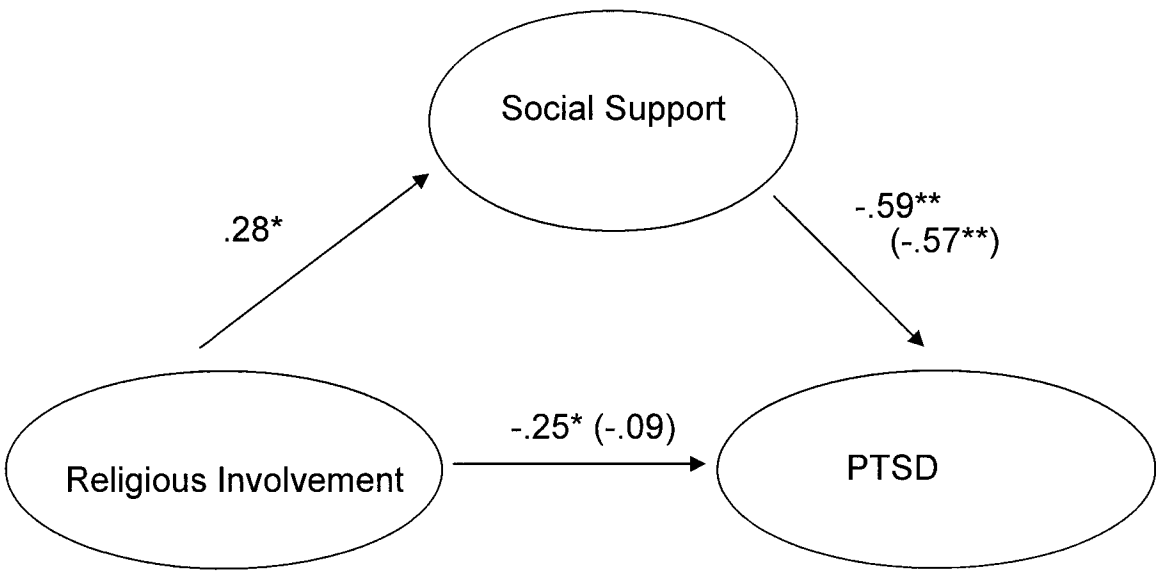
	Social Support	-1.00	.17	-.59**
Step 2				
	Social Support	-.96	.17	-.57**
	Religious Involvement	-.21	.22	-.09

Note. $R^2 = .36$ for Step 1; $\Delta R^2 = .01$ for Step 2; $F_{change} = .81$, $p > .05$
*$p < .05$
**$p < .01$

Figure 4. Social support mediating the relation between religious participation and Posttraumatic stress symptoms.



Model 5: Testing the Mediating Role of Religious Coping in the Spirituality-Women' Use of Physical Aggression Relation.

Only one of the criteria for showing mediation was supported as spirituality was related to religious coping. As table 4 illustrates, spirituality was not significantly related to women's use of physical aggression ($r = -.09$, $p > .05$). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Bivariate analyses

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revealed that religious coping was not significantly related to women's use of aggression (r = -.08, p>.05).

Model 6: Testing the Mediating Role of Social Support in the Religious Involvement-Women' Use of Physical Aggression Relation.

Only one criterion for showing mediation was met, as social support was related to religious involvement. As table 4 illustrates, religious involvement was not significantly related to women's use of physical aggression (r = -.17, p>.05). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Bivariate analyses revealed that social support was not significantly related to women's use of aggression (r = -.20, p>.05).

Model 7: Testing the Mediating Role of Religious Coping in the Spirituality-Utilization of Services Relation.

Because spirituality was found to be related to religious coping, only one criterion for showing mediation was met. As table 4 illustrates, spirituality was not significantly related to the number of services women utilized (r = .05, p>.05). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Bivariate analyses revealed that religious coping was not significantly related to the number of services that women used (r = -.01, p>.05). Because the data did not meet any of the first three criteria, the mediational model was not supported. Therefore, the mediational model was not tested.

Model 8: Testing the Mediating Role of Social Support in the Religious Involvement-Utilization of Services Relation.

Only the second criterion was supported for showing mediation, as social support

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was related to religious involvement. As table 4 illustrates, religious involvement was not significantly related to the number of services women utilized (r = .21, p>.05). Therefore, it was deemed unnecessary to enter the variables in a multiple regression equation. Further, bivariate analyses revealed that social support was not significantly related to the number of services that women used (r = .21, p>.05). Because the data did not meet any of the first three criteria, the mediational model was not supported. Therefore, the mediational model was not tested.

The Predictive Capacity of Religious Variables Above and Beyond Traditional Forms of Coping

Next, for exploratory purposes, I wanted to determine whether religious forms of coping predicted depression symptoms and posttraumatic stress symptoms, above and beyond the prediction afforded by more traditional forms of coping. The first step in the regression included traditional forms of coping, and the second step included the religious variables (religious coping, religious involvement and spirituality). Tables 12 and 13 reveal that the religious coping variables did not predict depression symptoms or PTSD symptoms above and beyond traditional means of coping (emotion-focused and problem-focused coping). This appears to be the case because emotion-focused coping was strongly related to both the outcome of interest (depression symptoms and PTSD symptoms) and some of the religious coping variables. Therefore, emotion-focused coping in particular may account for associations between religious variables (i.e., spirituality, religious coping and religious involvement) and negative mental health outcomes (depression and PTSD symptoms).

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Table 12. Summary of Stepwise Regression Analyses for Religious Variables Predicting Depression Symptoms.

Variable	B	*SE B*	*ß*
Step 1			
Emotion-focused Coping	-1.71	.44	-.50**
Problem-focused Coping	.69	.49	.17
Step 2			
Emotion-focused Coping	-1.37	.48	-.40
Problem-focused Coping	.58	.58	.15
Spirituality	-.17	.14	-.17
Religious Coping	.55	.67	.12
Religious Involvement	-.21	.23	-.13

Note. R^2 = .20 for Step 1; ΔR^2 = .04 for Step 2; F_{change} = 3.18, p>05
*p<.05
**p<.01

Table 13. Summary of Stepwise Regression Analyses for Religious Variables Predicting PTSD Symptoms.

Variable	B	*SE*	*ß*
Step 1			
Emotion-focused Coping	-2.49	.54	-.57**
Problem-focused Coping	1.49	.62	.30*
Step 2			
Emotion-focused Coping	-2.17	.60	-.49**
Problem-focused Coping	1.37	.73	.27

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Spirituality	-.09	.17	-.07
Religious Coping	.57	.84	.09
Religious Involvement	-.26	.28	-.12

Note. $R^2 = .25$ for Step 1; $\Delta R^2 = .02$ for Step 2; $F_{change} = .58$, $p > .05$
*$p < .05$
**$p < .01$

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Discussion

The present study sought to examine ways in which religious variables are associated with negative mental health outcomes and responses to violence among African American women who were victims of domestic violence. It was hypothesized that spirituality and religious involvement would be related to fewer depressive symptoms and posttraumatic stress symptoms; and that these variables would be related to these outcomes through the mediating roles of religious coping and social support. Study results indicated that African American women who reported higher levels of spirituality and greater religious involvement reported fewer depressive symptoms. Religious involvement was also found to be negatively associated with posttraumatic stress symptoms. The association between spirituality and depression remained significant after controlling for physical abuse characteristics and personal income. Findings further revealed, consistent with the hypotheses, that women who reported higher levels of spirituality reported utilizing higher levels of religious coping strategies and women who reported higher levels of religious involvement reported higher levels of social support. Finally, consistent with the hypotheses, social support mediated the relation between religious involvement and negative mental health outcomes. Contrary to the hypotheses, however, religious coping did not mediate the relation between spirituality and negative mental health outcomes.

Religious Coping in the Spirituality-Mental Health Link

The significant association found between spirituality and depression provides evidence for the important role of this variable in the lives of African American women. Over half the sample reported very high levels of spirituality. This is consistent with

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research that has shown that African Americans, in general, show high levels of spirituality when compared to other ethnic groups in the United States (e.g., Hill et al., 1995). Further, domestic violence victims in this sample indicated mild to severe levels of depression, on average, consistent with prior research (e.g., Fowler, 2002; Kocot & Goodman, 2003). Additionally, other studies have found this same association between depression and spirituality (e.g., Brome, Owens, Allen, & Vevaina, 2000; Sullivan, 1993), and one study has found this association particularly for African American abused women (Fowler, 2002).

It is noteworthy to mention that the association between spirituality and depression remained significant after controlling for other variables that are theoretically related to depression – physical assault, psychological abuse, time since most recent episode of abuse, and personal income. Because this was quite a stringent test of the association, this finding provides strong empirical evidence that spiritual experiences such as connection with the transcendent, gratitude, compassion, and support from the transcendent are associated with less depression symptoms (e.g., sadness, pessimism, worthlessness) even after one accounts for severity of violence, psychological aggression, time since last abusive episode and personal income among African American women who experience physical abuse. Indeed, the reverse explanation would indicate that those who experience higher levels of depressive symptoms are less likely to engage in spiritual practices. For instance, it is likely that concepts that partially define depression such as hopelessness, pessimism, and emptiness would be negatively correlated with spiritual concepts of finding meaning in life, optimism, and gratitude. In fact, the trauma literature has begun to address this phenomenon in more detail (e.g., Falsetti, Resick, &

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Davis, 2003), suggesting that disruptions in one's belief system can influence one's religious beliefs. Longitudinal studies are needed to untangle the temporal order and direction of these effects.

On the other hand, spirituality was not significantly associated with posttraumatic stress symptoms in this sample. This finding is contrary to research that has found that abused women who reported high levels of intrinsic religiosity suffer less severe PTSD symptoms than women without a high level of intrinsic religiosity (Astin et al., 1993). Further, studies of other traumatized populations have found spirituality to be negatively correlated with trauma symptoms (e.g., Smith et al., 2000). However, a study using a population similar to the current sample did not find this association to be significant (Fowler, 2002). Because the non-significant association between spirituality and posttraumatic stress symptoms is consistent with Fowler's study using a similar sample, it is likely that spirituality is not significantly related to posttraumatic stress symptoms for African American victims of domestic violence.

Indeed, the literature addressing posttraumatic stress symptoms and spirituality has been quite mixed with some authors suggesting that trauma can weaken spirituality (e.g., Calhoun & Tedeschi, 1999) and others suggesting that traumatic exposure can strengthen one's spirituality (e.g., Calhoun et al., 2000). Of note, this literature does suggest a reverse causal pathway (trauma influencing spirituality versus spirituality influencing trauma symptoms), however, it is mentioned because the failure to find a significant inverse association between spirituality and posttraumatic stress symptoms ($r = -.20$) in the current study may speak to the complex relation between trauma and one's spirituality. Posttraumatic stress symptoms may be the result of a conflicted belief

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system (Decker, 1993), and can result in disruptions in religious and spiritual beliefs. For instance, Falsetti et al., (2003) found that PTSD status predicted change in religious beliefs, with 30% of those with PTSD reporting that they became less religious after a trauma and 20% reporting that they became more religious. In an earlier study investigating the association between PTSD and religious beliefs, results indicated that combat veterans with PTSD obtained lower scores on measures of religious orientation than those without PTSD (Kennedy, 1989, cited in Falsetti et al., 2003). Although victimization can influence alterations in one's religious belief system, research examining the association between trauma and religiosity is in its infancy, and further research is needed to determine those factors that may help to explain why some people turn toward religion in times of crisis while others turn away from religion. Finally, it is worth emphasizing that an association was found in the expected direction, although not significant.

Although spirituality was found to be related to religious coping, religious coping could not explain the association between spirituality and depressive symptoms. In fact, religious coping was not related to depression ($r = .00$) and was only slightly related to posttraumatic stress symptoms in a positive direction ($r = .06$). This is counter to studies that have found religious coping measures to be stronger predictors of outcomes of stressful situations than generic measures of religiousness (e.g., frequency of prayer, frequency of attendance, etc.) (Pargament, 1997). Pargament (1997) suggested that religious coping may account for the association between spirituality and mental health outcomes (e.g., Pargament, 1997). Indeed, the failure to find a significant inverse association between religious coping and mental health outcomes of depression

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symptoms and posttraumatic stress symptoms is notable.

Like spirituality, religious coping has been found to play a contributing role to positive mental health outcomes (e.g., Smith et al., 2000). Perhaps religious coping operates differently among domestic violence victims. The literature examining religious coping methods has examined victims of uniquely different traumas such as disaster and homicide. In one of the only studies examining religious coping among a domestic violence sample, Ake (2003) found a significant positive direct effect of negative religious coping on trauma symptoms, but did not find a significant negative effect for positive religious coping on this outcome. Positive religious coping is an expression of a sense of spirituality, a secure relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others (Pargament et al., 1998). On the other hand, negative religious coping is an expression of a less secure relationship with God and a religious struggle in search of significance (Pargament et al., 1998). It is likely that negative religious coping mechanisms have a stronger influence on negative mental health outcomes than positive religious coping mechanisms for domestic violence victims. Future studies should include measures of both positive and negative religious coping in order to understand how they may influence positive and negative mental health outcomes among domestic violence victims.

Finally, it is also possible to conceptualize religious coping as a moderating variable in these associations. This view suggests that the relationship between spirituality and mental health outcomes may differ depending upon one's degree of religious coping. For example, spirituality may be more negatively associated with negative mental health conditions for those with high levels of religious coping compared

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to those with low levels of religious coping. Future studies may consider the moderating role of religious coping in their theoretical models.

Social Support in the Religious Involvement-Mental Health Link

African Americans generally tend to report higher levels of religious involvement than other ethnic groups (Jang & Johnson, 2004). When examining the 2-item measure of religious involvement[10], over half the sample reported very high levels of religious attendance. The significant association found between the 8-item measure of religious involvement and the mental health outcomes of depression symptoms and posttraumatic stress symptoms provides evidence for the important role of this variable in the lives of African American women. Indeed, this finding is consistent with other studies finding a significant inverse association between religious involvement and negative mental health outcomes (Koenig & Larson, 2001), suggesting that the religiously active are less likely to become depressed and experience trauma symptoms. However, when more stringent tests (i.e., controlling for abuse characteristics and personal income) examining the association between religious involvement and depression were employed, the association failed to remain significant. Similarly, the association between religious involvement and posttraumatic stress symptoms failed to remain significant after more stringent tests were employed. Past research has shown that when covariates are controlled, the association between religious involvement and depression tend to adjust downward (Ferraro, 1998).

It is worth emphasizing that despite the non-significant associations found between religious involvement and mental health outcomes after controlling for the

[10] The 2-item measure is cited here because it specifically looked at religious attendance. The other questions looked at frequency of engaging in religious behaviors like prayer, meditation, etc.

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covariates, it was deemed appropriate to continue with the mediation analyses. However, failure to find an association after controlling for abuse characteristics and personal income suggests that the association between religious involvement and mental health outcomes may involve processes associated with other variables such as socioeconomic factors. Therefore, the findings in the study should be interpreted with caution, as it is possible that social support would not be a mediating variable among those who, for instance, have access to more financial resources or experience less frequent physical abuse and psychological aggression. However, the decision was made to not include covariates in the analyses because inclusion of covariates could also distort valid associations. For example, perhaps those with few financial resources are less likely to participate in religious activities, and also have less social support. Nevertheless, the links between religious involvement and social support could still be valid, but influenced by SES. Future research should apply this mediation model to different socio-economic groups and groups who experienced different levels of physical aggression frequency in order to determine if the findings are consistent.

The association between religious involvement and both mental health outcomes in this study is worth emphasizing. The other religious variable, spirituality, only had a significant inverse association with the measure of depression, and religious coping was not significantly associated with the negative mental health outcomes of posttraumatic stress symptoms and depression. Pargament (1997) has argued that spirituality and religious coping exert a stronger influence on health than more global measures of religiosity (e.g., frequency of prayer, church attendance, etc.). It would seem likely that the measures of religious coping and spirituality would be able to predict both mental

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health outcomes based on Pargament's (1997) argument. The contrary findings suggest that religious involvement has a notable influence on negative mental health outcomes among African American survivors of domestic violence, and warrants further examination in this population. However, it is worth noting that the effect sizes for the associations between religious variables and mental health outcomes were relatively small (correlations in the .00-.26 range).

Another explanation for the association between religious involvement and both mental health outcomes is methodological. As mentioned earlier in the paper, the 8- item measure was selected to be used in the study as it had better reliability. In fact, the 2-item measure specifically assessed religious attendance while the 8-item measure assessed religious attendance (e.g., "How often do you attend religious services?") and private religious involvement (e.g., "How often have you read scriptures or Holy writings?"). Koenig, McCullough, and Larson (2001) label measures similar to the 8-item measure in this study *multi- item* measures of "general religious involvement" because they combine public religious involvement (e.g., frequency of church attendance) and private religious involvement (e.g., frequency of private prayer). They note that these measures are often reliable "since the measurement error associated with each individual item tend to cancel each other our when the items are aggregated" (p. 123). Since the other religious measures used in this study examined one dimension (i.e., spirituality or religious coping), it is likely that the multi-item nature of the measure to assess religious involvement in this study can account for its ability to find associations with both mental health outcomes, since exploratory analyses of the 2-item measure of religious attendance revealed no significant associations with the outcomes. Finally, it is

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likely that the 8-item measure has greater domain validity (covers more aspects of the construct), and therefore was better able to be significantly associated with both outcome measures.

Consistent with the hypothesis, social support was positively related to religious involvement. This confirms the theory that persons who actively involve themselves in religious communities are more likely to make supportive social contacts. Of course, future research would benefit from exploring third variable explanations that link social support and religious involvement. It is likely, for instance, that those who are religiously active and have a high level of social support also are highly optimistic. In fact, there is some literature that suggests that religion beliefs promote optimism, positive thinking, hope, and internal locus of control (Koenig et al., 1990). Likewise, it would be interesting to consider how these variables might explain the association between religious variables and various coping mechanisms like social support.

Also consistent with the hypotheses, social support was significantly related to depression symptoms and posttraumatic stress symptoms after controlling for other variables that are theoretically related to depression – physical assault, psychological abuse, time since most recent episode of abuse, and personal income, and the effect sizes were rather large (correlations greater than .50). Because this was quite a stringent test of the association, this finding provides strong empirical evidence that social support is related to fewer depressive symptoms (e.g., sadness, pessimism, worthlessness) and trauma symptoms (e.g., trouble remembering important parts of the event, feeling emotionally numb) even after one accounts for severity of violence, psychological aggression, time since last abusive episode and personal income for this sample. This

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association is in the expected direction and is consistent with prior research.

Further, social support was found to mediate the association between religious involvement and the negative mental health outcomes of posttraumatic stress and depressive symptoms. This finding is inconsistent with Ellison et al.'s (2001) finding that measures of social support failed to explain religious effects on psychological distress, but is consistent with Jang and Johnson's (2004) findings among African Americans. Jang and Johnson (2004) found that the religious effects on distress are mediated by social support. They attributed the difference in findings between their study and Ellison et. al.'s as being due to the fact that their study only used an African American sample and that the mediating process of social support is more applicable to this group than other ethnic groups. Indeed, previous research suggests that African Americans report higher levels of religious involvement than their European American counterparts (e.g., Ellison, 1992) and that religious attendance is more predictive of positive mental health outcomes for African Americans than for European Americans (e.g., Blaine & Crocker, 1995). Further, religious institutions have served as instruments of social organization in the African American community (Moore, 1991). The data in this study are consistent with a social support mediation model, providing further support for the idea that the mediating process of social support in the religious involvement-mental health link is applicable to an African American population. In addition, this study confirms that this association is applicable to a domestic violence sample.

Exploratory Analyses

This study also sought to explore whether the above mentioned models could explain women's response to violence- use of services and women's use of aggression.

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Further, the predictive capacity of religious variables above more traditional measures of coping was examined. Although, the models were not supported, a few interesting findings are worth noting.

Interestingly, religious variables and the more traditional coping variables were not significantly associated with the number of services women utilized. However, number of services utilized was related to depression, such that women who reported using more services reported fewer depressive symptoms. This is consistent with studies that have found that women who utilize services report better quality of life and less depression when compared to women who do not receive services (e.g., Jouriles and colleagues, 1998; Sullivan & Bybee, 1999). In light of several investigations that have indicated African American women are less likely than European American women to make use of formal services (e.g., Hutchinson Hirschel,1998), the association between formal support services and positive mental health outcomes speaks to the importance of making formal support services known to this population and accessible to this population. Of note, the population sampled for this study is unique as most of the women were involved in shelter services (75.4%). It is also unclear whether length of involvement in services was related to less depression as this was not assessed. Perhaps community interventions could be employed that encourage clergy and community leaders to urge victims to seek help from formal support services.

With regard to women's use of aggression, none of the coping variables in the study were related to physical abuse perpetration by the woman. However, strong associations were found between the respondent's physical abuse perpetration and her physical and psychological abuse victimization. This finding is consistent with studies

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that have indicated that women are likely to reciprocate violence in response to victimization (e.g., Uzell and Peebles-Wilkins, 1989).

To date, there are no studies that examine the association between women's response to violence (e.g., use of aggression and use of services) and religious coping mechanisms. This study represents an initial attempt to examine such an association. Although religious variables were not found to be associated with women's responses to violence, the literature would benefit from future studies examining similar associations to determine if this finding is replicated. This would be especially interesting in light of the fact that African American women tend to be highly spiritual (Hill et al., 1995), but also tend to reciprocate violence more than their European-American counterparts (Peebles-Wilkins, 1989). Well designed studies that offer explanations for the link between spirituality and African-American women's use of aggression would offer a more comprehensive picture of the factors relevant to this population.of women.

Finally, religious coping variables were not able to predict depression and posttraumatic stress symptoms after accounting for more traditional forms of coping. Pargament (1997) noted that religious coping adds unique variance to the prediction of health and well being above and beyond the effects of measures of nonreligious coping. The findings from this study are counter to the idea that people are more likely to access religious forms of coping during times of stress (e.g., Koenig, George, & Siegler, 1988; Pargament et al., 1990). In this case, emotion-focused coping appeared to have a stronger association with negative mental health outcomes. It is likely that emotion-focused coping's association with the outcomes is due to the fact that the items measured an aspect of social support as respondents were asked to indicate the extent to which they

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got moral support, sympathy and understanding from friends when confronted with the abuse. Indeed, the ISEL also had significant associations with mental health outcomes. Conceptually, emotion-focused coping as examined in this study (i.e., "seeking social support") and social support measured by the ISEL are quite similar as social support refers to resources provided by other people. Of note, the ISEL measures perception of social support, whereas *Seeking Social Support* measures the extent to which the participant sought out support. Indeed, other dimensions of emotion-focused coping not assessed in this study are considered maladaptive (e.g., use of drugs or alcohol or minimizing the impact of the stressor); however, this more adaptive form of emotion-focused coping appears to share some similiarties with the ISEL and may explain its associations with outcomes in the study. Of note, this was the first study that explored this association in a domestic violence sample. Victims of domestic violence may access a variety of coping mechanisms based on the ecological context of their lives. Waldorp and Resick (2004) have noted that predictors of coping strategies could include frequency and severity of physical abuse, length of relationship with the perpetrator, access to resources, and prior effectiveness of coping strategies. Therefore, this study revealed that for this sample of abused, African American women, emotion-focused coping was a more powerful coping resource. Future studies should consider in more detail the specific predictors of the coping strategies that abused women utilize.

Limitations

Several limitations in the present study are worth addressing. First, the sample size in the study is relatively small. It is possible that non-significant associations between the coping variables and mental health outcomes were due to the small sample

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size. For example, some correlations were in the expected direction but not quite significant, including the association between posttraumatic stress symptoms and spirituality (r = -.20). Further, the failure of previously significant associations (e.g., religious involvement and mental health outcomes) to remain significant after controlling for abuse characteristics and personal income may be due to the small sample size. Further research is needed with larger samples in order to determine if these findings would be significant if the study were replicated with greater statistical power. However, it is also important to note that the effect sizes for the associations between mental health variables and religious variables were rather small (r = .00 to .28), whereas the effect sizes for the associations between social support and mental health outcomes were large (greater than .50).

A second concern warranting attention is the cross-sectional, correlational nature of the design. Based on such a design, the direction of effects is unclear. Several studies examining coping mechanisms in the lives of abused women have noted the limitations of cross-sectional studies (e.g., Kocot & Goodman, 2003). Cross-sectional studies make it difficult to untangle the direction of the effects. For example, it is difficult to ascertain if spirituality affects mental health or if mental health affects spirituality. Further, longitudinal data are needed to gain a more thorough, accurate understanding of the process and causal associations in stress and coping.

Sampling is a third issue of concern for this study. Most of the participants (90.8%) in this study were drawn from a help-seeking population. Waldrop and Resick (2004) have suggested that help-seeking participants may not reflect the population of domestic violence survivors as a whole. It is likely, for example, that help-seeking

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women can differ from community samples in the frequency and severity of abuse, their social support network, religious involvement and their access to tangible forms of help. Indeed, the literature examining help seeking among African American victims has clearly indicated that this group is less likely to use formal services when compared to their European-American counterparts. Therefore, this sample of African American women may be uniquely different from most African American survivors. Future studies should examine such coping mechanisms among community samples.

Fourth, another apparent limitation is that the generalizability of the study is confined to African American female victims of domestic violence. Although this is the purpose of the study, it is important to note that this study does not provide information on the role of such variables in the lives of non-African American women.

Fifth, the quantitative nature of the study prohibits women from speaking and defining the variables for themselves. Likewise, it is difficult to discern if the measures are adequately tapping into the constructs as defined by this population of abused women.

Finally, the data were based on self-report measures obtained from the women only. This is problematic as studies have revealed that agreement between spouses in their reporting of violence vary considerably (Margolin, 1987). Typically, victims tend to report more violence than perpetrators and the victim reports are less associated with social desirability measures than the perpetrators. Future research would benefit from collateral reports from partners and the inclusion of social desirability measures.

Indeed, it is likely that the study would also benefit from other sources of data on social support. For instance, it would be interesting to measure the number of social transactions one has and their satisfaction with the support system provided. It might also

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be interesting to examine the agreement between women's perception of social support and the social support reported by a friend/relative.

Implications for Psychological Research and Practice

Although this study has some apparent shortcomings, there are some potential implications that make the present study an important contribution to the literature. In regard to research implications, very few studies have examined culturally relevant protective factors that may mitigate against the negative effects of violence among African American women. Further, there has been a lack of group specific data on African American women's responses to intimate partner violence. In fact, Weaver et al. (2003) found that only 4.1% (15 of 366) of quantitative research articles published in the *Journal of Traumatic Stress* between 1990 and 1999 considered religious and spiritual variables. This study contributes to the literature by highlighting relevant coping mechanisms for this population. Indeed, spirituality and religious involvement emerged as important coping mechanisms for this sample. Traditionally, psychology has not paid much attention to religious and spiritual variables in research. The present study highlighted the role that these variables played for abused women and hopefully will serve to spark continued research in the area of religion/spirituality and domestic violence.

This study also has implications for clinical training and practice. Miller (1999) has noted that the historical underrepresentation of spiritual and religious issues in clinical training programs has resulted in a lack of sensitivity and clinicians, thus, may be unequipped to address such issues with their clients. Further, psychologists may inappropriately evaluate the role of religion in the lives of their clients as psychologists

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tend to be much less religious than the general population (Pargament, 1997). Attending to client's spiritual and religious issues is an important aspect of being a multiculturally competent counselor and has vital implications for the delivery of mental health services. In fact, the American Psychological Association (1992) ethical principles underscore the importance of religion as an important aspect of human diversity that deserves appropriate attention when providing services (Standard 1.08). The findings from this study confirm that spirituality and religious involvement are culturally relevant coping mechanisms for this sample of African American women, suggesting that clinicians should consider ways in which they might use religion/spirituality as a therapeutic tool. Although there is no empirical evidence to determine the effectiveness of interventions targeting spiritual issues, several authors have written about techniques that one might consider when working with clients who consider religion/spirituality to be important (e.g., Drescher & Foy, 1995; Ganje-Fling & McCarthy, 1996). Future research should examine the effectiveness of interventions that incorporate spiritual/religious issues. Further, findings from this study should serve to encourage training programs to emphasize religious diversity so that future psychologists will be prepared to consider such issues in order to enhance treatment.

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APPENDIX 1: MEASURES

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APPENDIX A: Demographic Questionnaire

Background Information

1. Age: _____

2. What is your educational status? (**Please check only one**)
   1. did not finish high school and no GED? ___
   2. did not finish high school but have a GED? ___
   3. High school diploma? ___
   4. Some college? ___
   5. Bachelor's degree? ___
   6. Graduate school? ___

3. How would you describe your employment status?
   1. Full time employment ___
   2. Part-time employment ___
   3. Unemployed but worked within the past year ___
   4. Unemployed and did not work in the past year ___

4. Including income from all sources, such as work, child support, public assistance, how much money did you personally (not your partner) make in the past year before taxes?

1. no income at all ___
2. $1 - 3,000 ___
3. $3, 001 – $5,000 ___
4. $ 5,001 - $10,000 ___
5. $10,001 - $15,000 ___
6. $15, 000 - $20,000 ___
7. $20, 001 - $25,000 ___
8. $30, 001 - $35,000 ___
9. $35, 001 - $40,000 ___
10. $40, 001 - $ 45,000 ___
11. $40, 001 - $ 45,000 ___
12. $45, 001 - $ 50,000 ___
13 $50, 001 - $ 55,000 ___
14. $55, 001 - $ 60,000 ___
15. $60, 001 - $ 80,000 ___
16. more than $80,000 ___

5. What is your racial/ethnic background?
   1. African ___
   2. Carribean ___
   3. African-American ___
   4. Any other Black background ____
      (*specify if you wish*) _____

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6. What is your present religious orientation? (**Please check one**)

a. Lutheran ___
b. Baptist ___
c. Pentecostal ___
d. Holiness ___
e. Nazarene ___
f. Buddhist ___
g. None ___
h. Presbyterian ___
i. Catholic ___
j. Episcopal ___
k. Methodist ___
l. Jewish ___
m. Atheist (no belief in God) ___
n. Muslim ___
o. Bahai ___
p. Unitarian/Unity ___
q. A.M.E. ___
r. Jehova's Witness ___
s. Agnostic (not sure what to believe) ___
t. Other: _____

Relationship Information

7. What is your current marital status?
   a. Married and living together with partner: ___
   b. Married but not living together currently: ___
   c. Not married and living together with spouse: ___
   d. Never married: ___
   e. Divorced: ___
   f. Widowed: ___

8. Are you currently involved in a relationship with the person who was abusive towards you?

   ___YES ___NO

9. If you are currently involved in a relationship with the person who was abusive towards you, how often do you see one another for the purpose of being a couple?

   a. daily or almost every day _____
   b. 3-5 times per week ___
   c. 1-2 time per week ___
   d. 1-3 times per week ___
   e. 1-3 times per month ___
   f. less than once a month ___
   g. never ___
   h. not applicable (I am not currently involved in a relationship with this person) ___

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10. If you and your partner are separated, how long have you been separated?
    1. Less than 1 week ___
    2. 1 to 2 weeks ___
    3. 3-4 weeks ___
    4. 1-2 months ___
    5. 3-4 months ___
    6. 5-6 months ___
    7. 7-9 months ___
    8. 10-12 months ___
    9. more than 12 months ___
    10. not applicable ___

11. How long ago was the most recent episode of abuse (this includes physical abuse like pushing, shoving, threats, hitting, etc.)? **(Please check only one item)**

    a) Less than 1 week ago ___
    b) 1 to 2 weeks ago ___
    c) 3-4 weeks ago ___
    d) 1-2 months ago ___
    e) 3-4 months ago ___
    f) 5-6 months ago ___
    g) 7-9 months ago ___
    h) 10-12 months ago ___

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APPENDIX B: CTS-2

THE CONFLICT TACTICS SCALE-VERSION 2 (CTS-2)

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times your partner did each of these things in the past **12 months**.

How often did this happen in the past **12 months**?

1 = Once in the past 12 months	**5 = 11-20 times in the past 12 months**
2 = Twice in the past 12 months	6 = More than 20 times in the past 12 months
3 = 3-5 times in the past 12 months	**7 = Not in the past 12 months, but it did happen before**
4 = 6-10 times in the past 12 months	**0 = This has never happened**

1. My partner showed care for me even though we disagreed.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
2. My partner explained his or her side of a disagreement.	1	2	3	4	5	6	7	0
3. My partner showed respect for my feelings about an issue	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
4. My partner said he was sure we could work out a problem.	1	2	3	4	5	6	7	0
5. My partner suggested a compromise to a disagreement.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
6. My partner agreed to try a solution to a disagreement that I suggested.	1	2	3	4	5	6	7	0
7. My partner insulted or swore at me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
8. My partner called me fat or ugly.	1	2	3	4	5	6	7	0.
9. **My partner shouted or yelled at me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
10. My partner stomped out of the room, house or yard during a disagreement.	1	2	3	4	5	6	7	0
11. **My partner accused me of being a lousy lover.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
12. My partner did something to spite me.	1	2	3	4	5	6	7	0
13. My partner threatened to hit or throw something at me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
14. My partner threw something at me that could hurt.	1	2	3	4	5	6	7	0
15. **My partner destroyed something belonging to me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**

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How often did this happen in the past **12 months**?

1 = Once in the past 12 months	**5 = 11-20 times in the past 12 months**
2 = Twice in the past 12 months	6 = More than 20 times in the past 12 months
3 = 3-5 times in the past 12 months	**7 = Not in the past 12 months, but it did happen before**
4 = 6-10 times in the past 12 months	**0 = This has never happened**

16. My partner twisted my arm or hair.	1	2	3	4	5	6	7	0
17. **My partner pushed or shoved me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
18. My partner grabbed me.	1	2	3	4	5	6	7	0
19. **My partner slapped me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
20. My partner punched or hit me with something that could hurt.	1	2	3	4	5	6	7	0
21. **My partner kicked me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
22. My partner slammed me against a wall.	1	2	3	4	5	6	7	0
23. **My partner beat me up.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
24. My partner choked me.	1	2	3	4	5	6	7	0
25. **My partner burned or scalded me on purpose.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
26. My partner used a knife or gun on me.	1	2	3	4	5	6	7	0
27. **I felt physical pain that still hurt the next day because of a fight with my partner.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
28. I had a sprain, bruise, or small cut because of a fight with my partner.	1	2	3	4	5	6	7	0
29. I needed to see a doctor because of a fight with my partner, but I didn't.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
30. I passed out from being hit on the head by my partner in a fight.	1	2	3	4	5	6	7	0
31. I went to a doctor because of a fight with my partner.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
32. I had a broken bone from a fight with my partner.	1	2	3	4	5	6	7	0
33. My partner insisted on sex when I didn't want to (but did not use physical force).	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
34. My partner insisted that I have oral or anal sex (but did not use physical force.)	1	2	3	4	5	6	7	0
35. **My partner made me have sex without a condom**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
36. My partner used threats to make me have sex.	1	2	3	4	5	6	7	0
37. **My partner used threats to make me have oral or anal sex.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
38. My partner used force (like hitting, holding down, or using a weapon) to make me have oral or anal sex.	1	2	3	4	5	6	7	0
39. **My partner used force (like hitting, holding down, or using a weapon) to make me have sex.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**

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Next, I have a brief list of things that **you may have done** when you had a conflict or disagreement with your partner. As you go on through the list, you may come to things that you have done in self-defense. I am in no way trying to blame or judge you for these things, but only trying to find out information on how often they have happened.

How often did this happen in the past **12 months**?

1 = Once in the past 12 months	**5 = 11-20 times in the past 12 months**
2 = Twice in the past 12 months	6 = More than 20 times in the past 12 months
3 = 3-5 times in the past 12 months	**7 = Not in the past 12 months, but it did happen before**
4 = 6-10 times in the past 12 months	**0 = This has never happened**

1. **I showed my partner care even though we disagreed.**	**1 2 3 4 5 6 7 0**
2. I explained my side of a disagreement to my partner.	1 2 3 4 5 6 7 0
3. **I showed respect for my partner's feelings about an issue.**	**1 2 3 4 5 6 7 0**
4. I said I was sure that we could work out a problem.	1 2 3 4 5 6 7 0
5. **I suggested a compromise to a disagreement.**	**1 2 3 4 5 6 7 0**
6. I agreed to try a solution to a disagreement that my partner suggested.	1 2 3 4 5 6 7 0
7. **I insulted or swore at my partner.**	**1 2 3 4 5 6 7 0**
8. I called my partner fat or ugly.	1 2 3 4 5 6 7 0
9. I **shouted or yelled at my partner.**	**1 2 3 4 5 6 7 0**
10.I stomped out of the room, house, or yard, during a disagreement.	1 2 3 4 5 6 7 0
11. **I accused my partner of being a lousy lover.**	**1 2 3 4 5 6 7 0**
12. I did something to spite my partner.	1 2 3 4 5 6 7 0
13. **I threatened to hit or throw something at my partner.**	**1 2 3 4 5 6 7 0**
14. I threw something at my partner that could hurt.	1 2 3 4 5 6 7 0
15. I destroyed something belonging to my partner.	**1 2 3 4 5 6 7 0**
16. I twisted my partner's arm or hair.	1 2 3 4 5 6 7 0
17. **I pushed or shoved my partner.**	**1 2 3 4 5 6 7 0**
18. I grabbed my partner.	1 2 3 4 5 6 7 0
19. **I slapped my partner.**	**1 2 3 4 5 6 7 0**
20. I punched or hit my partner with something that could hurt.	1 2 3 4 5 6 7 0
21. **I kicked my partner.**	**1 2 3 4 5 6 7 0**
22. I slammed my partner against a wall.	1 2 3 4 5 6 7 0
23. **I beat up my partner.**	**1 2 3 4 5 6 7 0**
24. I choked my partner.	1 2 3 4 5 6 7 0
25. **I burned or scalded my partner.**	**1 2 3 4 5 6 7 0**
26. I used a knife or gun on my partner.	1 2 3 4 5 6 7 0
27. **My partner still felt physical pain the next day because of a fight we had.**	**1 2 3 4 5 6 7 0**

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How often did this happen in the past **12 months**?

1 = Once in the past 12 months	**5 = 11-20 times in the past 12 months**
2 = Twice in the past 12 months	6 = More than 20 times in the past 12 months
3 = 3-5 times in the past 12 months	**7 = Not in the past 12 months, but it did happen before**
4 = 6-10 times in the past 12 months	**0 = This has never happened**

28. My partner had a sprain, bruise or small cut because of a fight with me.	1 2 3 4 5 6 7 0
29. **My partner needed to see a doctor because of a fight with me, but didn't.**	**1 2 3 4 5 6 7 0**
30. My partner passed out from being hit on the head in a fight with me.	1 2 3 4 5 6 7 0
31. My partner wnet to a doctor because of a fight with me.	**1 2 3 4 5 6 7 0**
32. My partner had a broken bone from a fight with me.	1 2 3 4 5 6 7 0

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APPENDIX C: THE CONFLICT TACTICS SCALE-VERSION 1 (CTS-1)

SCREENING TOOL

Please indicate whether your (ex)partner did any other the following things to you in the past year by checking YES or NO.

	YES	NO
1. My partner threw something at me		
2. My partner pushed, grabbed or shoved me.		
3. My partner slapped my.		
4. My partner kicked, bit or hit me with a fist.		
5. My partner beat me up.		
6. My partner choked me.		
7. My partner threatened me with a knife or a gun.		
8. My partner used a knife or fired a gun.		

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APPENDIX D: INTERPERSONAL SUPPORT EVALUATION LIST (ISEL)

For each statement, **circle** TRUE if the statement is true about you or FALSE if the statement is not true about you. **Circle only one of the alternatives for each statement.**

			Appraisal
True	**False**	1.	There is at least one person I know whose advice I really trust.
True	**False**	2.	There is really no one I can trust to give me good financial advice.
True	**False**	3.	There is really no one who can give me objective feedback about how I am handling problems.
True	**False**	4.	When I need suggestions for how to deal with a personal problem I know there is someone I can turn to.
True	**False**	5.	There is someone who I feel comfortable going to for advice about sexual problems.
True	**False**	6.	There is someone I can turn to for advice about handling hassles over household responsibilities.
True	**False**	7.	I feel there is no one with whom I can share worries and fears.
True	**False**	8.	If a family crisis arose few of my friends would be able to give good advice about handling it.
True	**False**	9.	There are very few people I trust to help solve my problems.
True	**False**	10.	There is someone I could turn to for advice about changing my job or finding a new one.
			Belonging
True	**False**	11.	If I decide on Friday afternoon that I would like to go to a movie that evening, I could find someone to go with me.
True	**False**	12.	No one I know would throw a birthday party for me.
True	**False**	13.	There are several different people with whom I enjoy spending time.
True	**False**	14.	I don't often get invited to do other things.
True	**False**	15.	If I wanted to have lunch with someone, I could easily find someone to join me.
True	**False**	16.	Most people don't enjoy the same things that I do.
True	**False**	17.	When I feel lonely, there are several people I could call and talk to.
True	**False**	18.	I regularly meet or talk with members of my family or friends.
True	**False**	19.	I feel that I am on the fringe of my circle of friends.
True	**False**	20.	If I wanted to go out of town (e.g., to the coast) for the day I would have a hard time finding someone to go with me.

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			Tangible
True	**False**	21.	If for some reason I were put in jail, there is someone I could call who would bail me out.
True	**False**	22.	If I had to go out of town for a few weeks, someone I know would look after my home (the plants, pets, yard, etc.)
True	**False**	23.	If I were sick and needed someone to drive me to the doctor, I would have trouble finding someone.
True	**False**	24.	There is no one I could call on if I needed to borrow a car for a few hours.
True	**False**	25.	If I needed a quick emergency loan of $100, there is someone I could get it from.
True	**False**	26.	If I needed some help in moving to a new home, I would have a hard time finding someone to help me.
True	**False**	27.	If I were sick, there would be almost no one I could find to help me with my daily chores.
True	**False**	28.	If I got stranded 10 miles out of town, there is someone I could call to come get me.
True	**False**	29.	If I had to mail an important letter at the post office by 5:00 and couldn't make it, there is someone who could do it for me.
True	**False**	30.	If I needed a ride to the airport very early in the morning, I would have a hard time finding anyone to take me.
			Self-Esteem
True	**False**	31.	In general, people don't have much confidence in me.
True	**False**	32.	I have someone who takes pride in my accomplishments.
True	**False**	33.	Most of my friends are more successful at making changes in their lives than I am.
True	**False**	34.	Most people I know think highly of me.
True	**False**	35.	Most of my friends are more interesting than I am.
True	**False**	36.	I am more satisfied with my life than most people are with theirs.
True	**False**	37.	I have a hard time keeping pace with my friends.
True	**False**	38.	I think that my friends think that I'm not very good at helping them solve problems.
True	**False**	39.	I am closer to my friends than most other people.
True	**False**	40.	I am able to do things as well as most other people.

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APPENDIX E: DAILY SPIRITUAL EXPERIENCES (DSE)

The list that follows includes items you may or may not experience. Please consider if and how often you have these experiences, and try to disregard whether you feel you should or should not have them. **In addition, a number of items use the word "God." If this word is not a comfortable one for you, please substitute another idea which calls to mind the divine or holy for you.**

1. I feel God's presence.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

2. I experience a connection to all life.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

3. During worship, or at other times when connecting with God, I feel joy, which lifts me out of my daily concerns.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

4. I find strength in my religion or spirituality.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

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5. I find comfort in my religion or spirituality.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

6. I feel deep inner peace or harmony.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

7. I feel guided by God in the midst of daily activities.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

8. I ask for God's help in the midst of daily activities.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

9. I feel God's love for me directly.
   6 – Many times a day
   5 – Every day
   4 – Most days
   3 – Some days
   2 – Once in a while
   1 – Never or almost never

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10. I feel God's love for me through others.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

11. I am spiritually touched by the beauty of creation.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

12. I feel thankful for my blessings.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

13. I feel a selfless caring for others.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

14. I accept others even when they do things I think are wrong.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

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15. I desire to be closer to God or in union with Him.
    6 – Many times a day
    5 – Every day
    4 – Most days
    3 – Some days
    2 – Once in a while
    1 – Never or almost never

16. In general, how close do you feel to God?
    4- As close as possible
    3-Very close
    2-Somewhat close
    1-Not at all close

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APPENDIX F: RELIGIOUS INVOLVEMENT

1. How often do you attend religious services? (Circle the appropriate answer)
   1-More than once a week
   2-Every week or more often
   3-Once or twice a month
   4-Every month or so
   5-Once or twice a year
   6-Never

2. Besides religious services, how often do you take part in other activities at a place of worship? (Circle the appropriate answer.)

   1. Never
   2. Less than once a year
   3. About once a year
   4. Several times a year
   5. About once a month
   6. 2-3 times a month
   7. Nearly every week
   8. Every week
   9. Several times a week

For the past 2 years, how often have you done the following? (circle <u>one number</u> for each line)

	Never	Rarely	Once a Month	Twice a Month	Once a Week	Twice a Week	Almost Daily	More than Once a day
Thought About God	1	2	3	4	5	6	7	8
Prayed	1	2	3	4	5	6	7	8
Meditated	1	2	3	4	5	6	7	8
Attended Worship Service	1	2	3	4	5	6	7	8
Read/study scriptures, Holy writings	1	2	3	4	5	6	7	8
Had direct Experiences With God	1	2	3	4	5	6	7	8

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APPENDIX G: COPING

Think about the abuse and how you responded to it **within the past year**. Then indicate the extent to which you did each of the following things using the following response choices: "I didn't do this at all'" I did this a little bit," I did this a medium amount," and "I did this a lot." **Please circle the appropriate response for each item**.

	I didn't do this at all	**I did this a little bit**	**I did this a medium amount**	**I did this a lot**
RELIGIOUS COPING				
1. I sought God's help	1	2	3	4
2. I put my trust in God	1	2	3	4
3. I tried to find comfort in my religion	1	2	3	4
4. I prayed more than usual	1	2	3	4
PROBLEM-FOCUSED COPING				
5. I took additional action to try to get rid of the problem	1	2	3	4
6. I concentrated my efforts on doing something about it	1	2	3	4
7. I did what was to be done, one step at a time	1	2	3	4
8. I took direct action to get around the problem	1	2	3	4
EMOTION-FOCUSED COPING				
9. I talked to someone about how I feel	1	2	3	4
10. I tried to get emotional support from friends or relatives	1	2	3	4
11. I discussed my feelings with someone	1	2	3	4
12. I got sympathy and understanding from someone	1	2	3	4

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APPENDIX H: UTILIZATION OF SERVICES

When people experience abuse in their relationship they may take certain actions to deal with the abuse. The following items are actions that some people may take to address the abuse. Please circle YES if you have taken that specific action in the past, circle NO if you have never taken that specific action, or circle N/A if these items do not apply to you (e.g., you may not have children).

In response to the abuse, have you ever....

1. Sought professional help for self (e.g., counseling, therapy)	YES	NO	N/A
2. Sought professional help for your child (e.g., counseling, therapy)	YES	NO	N/A
3. Suggested that the abuser get professional help.	YES	NO	N/A
4. Confronted the abuser about the abuse.	YES	NO	N/A
5. Moved out of your house or apartment	YES	NO	N/A
6. Made abuser move out of your house or apartment	YES	NO	N/A
7. Separated or got divorced	YES	NO	N/A
8. Sought emergency shelter	YES	NO	N/A
9. Asked friends or family for help	YES	NO	N/A
10. Engaged in safety planning for self/others	YES	NO	N/A
11. Informed others of problems with abuse	YES	NO	N/A
12. Notified authorities	YES	NO	N/A
13. Obtained an order from the court for your partner to stay away from you.	YES	NO	N/A

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APPENDIX I: BDI

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel discouraged about the future
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, all I can see is a lot of failure.
3 I feel I am a complete failure as a person.

4. Loss of Pleasure
0 I get as much pleasure out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get any real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5. Guilty Feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings
0 I don't feel I am being punished.
1 I feel I may be punished
2 I expect to be punished.
3 I feel I am being punished.

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7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decision

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14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up 1-2 hours earlier than usual and find it hard to go back to sleep
3 I wake up several hours earlier than I used to and cannot get back to sleep

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

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21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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APPENDIX J: PCL

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

The event you experienced was _____physical abuse_____ on _____.
(event) (date)

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing *memories, thoughts, or images* of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing *dreams* of the stressful experience?	1	2	3	4	5
3. Suddenly *acting or feeling* as if the stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4. Feeling *very upset* when *something reminded you* of the stressful experience?	1	2	3	4	5
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of the stressful experience?	1	2	3	4	5
6. Avoiding *thinking about or talking about* the stressful experience or avoiding *having feelings* related to it?	1	2	3	4	5
7. Avoiding *activities or situations* because *they reminded you* of the stressful experience?	1	2	3	4	5
8. Trouble *remembering important parts* of the stressful experience?	1	2	3	4	5
9. *Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10. Feeling *distant or cut off* from other people?	1	2	3	4	5

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11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your *future* somehow will be *cut short*?	1	2	3	4	5
13. Trouble *falling or staying asleep*?	1	2	3	4	5
14. Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15. Having *difficulty concentrating*?	1	2	3	4	5
16. Being "*superalert*" or watchful or on guard?	1	2	3	4	5
17. Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-S for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

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APPENDIX 2. TABLES

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APPENDIX K

Intercorrelations of Religious Measures and Subscales of the PCL checklist.

	1	2	3	4	5	6
1. PCL- Avoidance	--	.87**	.74**	-.30*	-.28*	-.02
2. PCL- Arousal		--	.76**	-.33*	-.19	.08
3. PCL-Reexperiencing			--	-.14	-.08	.10
4. Spirituality				--	.47**	.33**
5. Religious Involvement					--	.41**
6. Religious Coping						--

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APPENDIX L

Intercorrelations of Covariates with Mental Health Outcomes

	1	2	3	4	5	6
1. Time since most recent abusive episode	--	-.29*	-.28*	.31*	-.31*	-.34**
2. Physical Abuse		--	.77**	-.24	.38**	.41**
3. Psychological Abuse			--	-.25*	.25*	.33**
4. Personal Income				--	-.28*	-.38**
5. Posttraumatic Stress Symptoms					--	.72**
6. Depression Symptoms						--

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